DATE:_____

HILL ORTHOPEDIC CENTER, LLC

MRN:_____

Personal and Contact Information/ *Información Personal y Contacto*

Full (Legal) Name: :_____ **Date of Birth:** _____
Nombre legal completo *Last, Full, Middle Initial* *Fecha de nacimiento*

Please circle: **Male** ***or*** **Female** **Social Security #:**_____
circule por favor *Masculino* *o* *Femenino* *Seguro Social:*

Address: _____ **Home Phone:** (___) ___-____
dirección _____ *teléfono de casa*

City, State, Zip (ciudad, estado,código postal) **Cell Phone:** (___) ___-____
celular

Email/ *correo electrónico* :_____

Marital Status/ Estado civil : *please circle (circula por favor)*

Single/*soltero* - **Married**/ *Casado* - **Divorced**/ *Divorciado* - **Separated**/ *Separado* - **Widowed**/ *viudo*

Employement History/ *Historia de Empleo*

Are you currently employed? / *Está trabajando actualmente?* **Yes**/ *Si* **No**/ *No*

If Yes, please provide us with the following information.
Si es así , por favor indíquenos con la siguiente información ?

What is your **occupation?**/ *¿Cuál es su ocupación?*:_____

Who is your **employer?** *¿Quién es su empleador ?*:_____

Work **phone**/ *Teléfono del trabajo* : (_____)_____

Emergency Contact Information/ *Información de contacto de emergencia*

Please provide us with the following information in case of an emergency
Por favor proporcione la siguiente información en caso de emergencia

Name/ *Nombre* : _____

Phone Number /*número de teléfono* :_____

Relationship to patient /*Relación con el paciente* : _____

Name/ *Nombre* : _____

Phone Number /*número de teléfono* :_____

Relationship to patient /*Relación con el paciente* : _____

Insurance information / *información del seguro:*

Auto Insurance / *seguro de auto:*

Name of insurance/ *Nombre del seguro:* _____

Policy Number/ *número de póliza:* _____

Have you notified your insurance carrier?/ *¿Ha notificado su compañía de seguros ?* Yes/ *Si* No/ *no*

If YES, were you assigned a claim number? Yes No
En caso afirmativo , ¿A sido asignado un número de reclamo ? *Si* *No*

If YES, what is your claim number?: _____
En caso afirmativo , ¿cuál es su número de reclamo ?

Were you assigned an adjuster? *¿Le han asignado un ajustador ?* Yes/ *Si* No/ *no*

If yes, what is your adjuster's name? _____
En caso afirmativo , ¿cuál es el nombre de su ajustador ?

Are you the policy holder?/ *Usted es el dueño de la poliza?* Yes/ *Si* No/ *no*

Policy Holder/ *Due ño de poliza :* _____

Policy holder's FULL legal name/*El nombre del dueño de la póliza :* _____

Policy holder's Phone Number/*número de teléfono del dueño de la póliza:* _____

Relationship to patient /*Relación con el paciente* : _____

Health Insurance/ *Seguro De Salud:*

Name of insurance/ *Nombre del seguro:* _____

Policy Number/ *número de póliza:* _____

Are you the policy holder?/ *Usted es el dueño de la poliza? ?* Yes/ *Si* No/ *no*

Policy Holder/ *Due ño de poliza :* _____

Policy holder's FULL legal name/*El nombre del dueño de la póliza :* _____

Policy holder's Phone Number/*número de teléfono del dueño de la póliza:* _____

Relationship to patient /*Relación con el paciente* : _____

Were you referred to our office? *¿Fue referido a nuestra oficina ?* Yes/ *Si* No/ *no*

If YES, whom do we need to thank? _____
En caso afirmativo , ¿a quién tenemos que dar las gracias ? *Name & Number (Nombre y número)*

Auto Accident Information/ *información de accidente de auto*

Date of accident/ *fecha del accidente* :_____

Please circle a response for the following questions. *Por favor marque una respuesta para las siguientes preguntas.*

Where you the/ *usted era:* **Driver** *conductor* OR **Passenger** *pasajero*

Were you wearing a seat belt?/ *¿Estabas usando el cinturón de seguridad ?* **Yes/** *Si* **No/** *no*

Were You stopped? / *estabas parado?* **Yes/** *Si* **No/** *no*

Were you traveling?/ *estabas viajando?* **Yes/** *Si* **No/** *no*

Were you struck? *Te golpearon?* **Yes/** *Si* **No/** *no*

Did your airbags deploy? *¿Sus bolsas de aire se despleguron?* **Yes/** *Si* **No/** *no*

Did police or ambulance arrive at the scene?/ *hubo alguna respuesta de emergencia?* **Yes/** *Si* **No/** *no*

Were you seen at an emergency room?*¿Fuistes visto en una sala de emergencia?* **Yes/** *Si* **No/** *no*

If yes, which hospital? *En caso afirmativo, en qué hospital ?:*_____

What day were you seen?/ *¿Qué día fuistes visto?* _____

Were you taken by ambulance? *¿Fue trasladado en ambulancia?* **Yes/** *Si* **No/** *no*

Course of treatment /*Curso de tratamiento :*

Were radiologic studies performed? *Se realizaron estudios radiológicos?* **Yes/** *Si* **No/** *no*

If so, what? (Please circle ALL that apply)/ *Si es así , ¿qué. (Por favor marque todas las que correspondan)*

X-rays CT Scans MRI Ultrasound

☐Check here if you have not had any medical treatment.

Marque aquí si usted no ha tenido ningún tratamiento médico.

Did you have any follow up care? *¿Tuvo alguna atención de seguimiento ?* **Yes/** *Si* **No/** *no*

If so, please choose from below. *Si es así, por favor elegir desde abajo.*

Chiropactor/ *quiropráctico:* **Yes/** *Si* **No/** *no*

Family Doctor /*médico de cabecera* : **Yes/** *Si* **No/** *no*

Orthopedic /*ortopédico* : **Yes/** *Si* **No/** *no*

Neurologist, Spinal or Neurosurgeon/ *neurólogo* : **Yes/** *Si* **No/** *no*

OTHER/ *otro* : _____

Medical History/ *historia médica*

Please place a check beside all that apply to you presently or have in the past.
Por favor, coloque una marca al lado de todo lo que aplique en su caso en la actualidad o en el pasado .

Past and present medical history. *Historial médico pasado y el present.*

Stomach ulcers	Sleep Apnea	Tuberculosis	Thyroid (Hypo or Hyper)
COPD	Asthma	Diabetes: I or II	Cancer: _____
Bronchitis	Heart Attack	Shortness of breath	Osteoporosis
Emphysema	Stroke	Chest Pains	Osteoarthritis
Kidney Disease	Migraines	Angina	Rheumatoid Arthritis
Kidney Stones	Gout	Dizzy or fainting spells	Back Pain
GERD	Anemia	MRSA	Neck Pain
Depression	Hep-C	Neuropathy	Epilepsy/ Seizures
AIDS OR HIV	Anxiety	Joint pains/swelling	Carpal Tunnel
Bipolar	High Cholesterol	Alzheimer's	High Blood Pressure

Other/ *Otro:* _____

_____

_____

Surgical history */cirugías pasadas*

Colonoscopy	Prostate	Eye Surgery	Hysterectomy: Total or Partial
Ileostomy	Pacemaker	Cosmetic	Knee Arthroscopy: L or R
Mastectomy	Appendix	Fracture Repair	Shoulder Arthroscopy: L or R
Heart Surgery	Hernia repair	Kidney	Total Knee Replacement: L or R
Angioplasty	Tonsils-Adenoids	Cancer removal	Total Hip Replacement: L or R
Stents	Tubal Ligation	Gall bladder	Total Shoulder Replacement: L or R
C-section			

Other/ *Otro:* _____

_____

_____

Family Medical History: *médico familiar*

Heart Attack	Diabetes	Heart Disease	High Cholesterol
High blood pressure	Cancer	Stroke	Kidney Disease

Other/ *Otro:* _____

_____

_____

Office Use Only

Height	Weight	Temperature	Blood Pressure

Medication:

We have taken the liberty of listing some common medications for common ailments, please mark those that you are currrently taking.

Nos hemos tomado la libertad de enumerar algunos medicamentos comunes para enfermedades comunes , por favor marque los que usted está tomando actualmente .

High Blood Pressure	Anti-inflammatories	Diabetes	High cholesterol	Psych
LISINOPRIL	*Naproxen (Aleve)*	*Metformin*	*Simvastatin*	*Zoloft*
ATENOLOL	*Ibuprofen (Motrin)*	*Januvia*	*Lipitor*	*Paxil*
METOPROLOL	*Celebrex*	*Insulin*	*Lovastatin*	*Zanax*
HCLZ	*Anaprox*	*Glimipride*	*Pravastatin*	*Seroquel*
LOSARTAN	*Mobic*	*Glyburide*	*Fenofibrate*	*Depakote*

Please list any other medications you are currently taking . Please include prescriptions, over the counter medications, and/ or vitamins.

Por favor escriba cualquier otro medicamento que esté tomando . Por favor incluya recetas, medicamentos de venta libre , y / o vitaminas .

Please list all known allergies. If you do not have any, please circle NKDA for no known drug allergies.

Por favor enumere todas las alergias conocidas. Si no tienes ninguno, por favor circule NKDA para sin alergias medicamentosas conocidas.

Common Allergies/ *alergias comunes*

Penicillin	Sulfa	Iodine	Latex	Adhesive	Lidocaine	Codeine	Morphine	NKDA

Please provide us with your pharmacy information so we can e-scribe your medications.

Por favor indíquenos su información de la farmacia para que podamos E-scribe sus medicamentos.

Name of Pharmacy *Nombre de la farmacia* : _____

Phone Number/ *número de teléfono* : _____

Intersection or address/ *Intersección o dirección* : _____

X _____ **Date/** *fecha:* _____

Signature/ Firma

HILL ORTHOPEDIC CENTER, LLC

FINANCIAL AGREEMENT

____ On behalf of the patient receiving services from Hill Orthopedic Center LLC, I accept responsibility to ensure that all services are paid in full within 60 days according to the following guidelines:

- In the event the patient does not have health insurance coverage, I will make payment when services are rendered or I will establish a budget plan with the Center's Patient Financial Services Department.
- In the event the Insurance Company does not have a contractual arrangement with Hill Orthopedic Center LLC, I assume full responsibility for payment of charges not covered by insurance.
- In the event the Insurance Company has a contractual arrangement with Hill Orthopedic Center LLC, I agree to pay the applicable co-payments, deductibles, and co-insurance.

RELEASE OF INFORMATION

____ I authorize Hill Orthopedic Center LLC to release any information acquired in the course of my medical examination and treatment (including drug use, alcoholism and HIV positive test results), to my insurance company, third party payers, case utilization and managed care review companies, the Health Care Financing Administration and its agents which may be necessary in order for the Clinic to determine benefits, to obtain authorization or to receive payment for my care. I further authorize information to be released to all other Hill Orthopedic Center LLC agencies, affiliated institutions, or individuals who will be providing healthcare or social services to me.

ASSIGNMENT OF BENEFITS

____ I authorize payment directly to Hill Orthopedic Center LLC for the surgical and/or medical benefits otherwise payable to me under the terms of the policy but not to exceed the balance due to physicians, and/or other providers for services provided during my treatment. In making this assignment, I understand and agree that I may be financially responsible to Hill Orthopedic Center LLC for charges not paid by my insurance policy(ies). I permit a copy of this authorization to be used in place of the original.

OFFICE POLICY AND PROCEDURES

____ We now have digital x-rays in our Orlando and davenport locations, should you need a copy of your x-rays the following fees will apply, $25.00 per disk. These fees are not covered by insurance and must be paid prior to receiving your copy.

____ We do not call in new prescriptions, the patient is required to come to our office and obtain a new prescription. Any patient losing a prescription will be required to pay a $5.00 duplication fee. We do not call in refills for any prescriptions on Saturday or Sunday. Please be sure to contact our office, by no later than Thursday before 5:00pm for any refills or medication changes that you may need.

____ This office charges a fee of $25.00 for all forms that you ask the physician and\or staff to complete (ex. Insurance Company, Employer Attorney and Disability Forms) this fee will be paid when dropping off forms and the completed form may be picked-up in 7 business days. These fees are not covered by insurance and must be paid prior to receiving your copy.

____ Any patient that comes in without a valid referral from physician and\or carrier will be required to pay all office charges in full at time of visit. All co pays and co-insurance will be due at time of visit, if you are unable to pay, your appointment will be rescheduled.

____ There will be a $30.00 charge for all appointments that are not cancelled or rescheduled with our office within 24 hours of appointment.
It is required that you speak to our staff and not leave a voicemail message. Any surgery you schedule and you must cancel ,there will be a 250.00 dollar charge. if cancelled within 2 weeks of the surgery

____ There is a $50.00 fee for all checks that are returned for Non Sufficient Funds and the check will need to be picked up within 15 days from notification of an NSF check or will be turned over to the OCSO for restitution. Payment will need to be in full (service charge) in cash or money order made payable to Hill Orthopedic Center, LLC.

Copies of this is available, please see the office manager for a copy.

Patient Signature _____ **Insured's Signature** _____ **Date** _____
(Parent/Guardian of Minor) **(Parent/Guardian of Minor)**

Witness Signature _____ **Date** _____ **Time** _____

4125 Hunters Park Lane
Suite 117
Orlando, FL 32837
Phone 407-447-7001

Fax 407-447-7006

40124 U.S. Highway 27
Suite 205
Davenport, Fl 33837
Phone 863-422-1734

Fax 863-421-1975

540 S. Chickasaw Trail
Orlando, Fl. 33837

Phone 407-985-3977

Fax 407-985-1961

NOTICE OF PATIENT PRIVACY PRACTICES
LEGAL FORM AND CONSENT

Form of Written Acknowledgement of Receipt of Hill Orthopedic Center, LLC Notice of Patient Privacy Practices (NPPP)

This will indicate, by signing this Written Acknowledgment of Receipt that I have received the HIPAA Notice of Patient Privacy Practices document (NPPP) issued at Hill Orthopedic Center, LLC

Patient, or Legal Representative, Signature

_____

Printed Name of Patient, or Legal Representative

_____

Date_____

Acknowledgement NOT obtained because:
____ Patient, or legal representative, declined Notice of Patient Privacy Practices (NPPP)

____ Patient treated in emergency room and discharged before obtaining Acknowledgment;

____ Other (briefly describe) _____

Patient Signature _____ **Date** _____

Patient Printed Name _____

HILL ORTHOPEDIC CENTER, LLC

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **This consent will remain in full force until revoked in writing.**

I, the undersigned, authorize that Hill Orthopedic Center, LLC will use and disclose my information for the purpose of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient. Such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which, in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Healthcare Operations include but not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infections diseases including but not limited to blood-borne diseases.

A photocopy of the consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the State of Florida Health Department and appropriate counseling will be offered.

Medicare Patients: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Hill Orthopedic Center, LLC.

I acknowledge that I have been given the Hill Orthopedic Center, LLC Notice of Privacy Practices. I understand that if I have questions or complaints, that I should contact the Privacy Official. **Patient Initial:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____	_____
Print Name	**Patient (or Responsible Party) Signature**	**Date**

_____	_____
Witness Signature	**Date**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Hunters Creek
4125 Hunters Park Ln, Ste 117
Orlando, FL 32837
Ph: 407-447-7001
Fax: 407-447-7006

East Orlando
540 S Chickasaw Trail
Orlando, FL 32835
Ph: 407-985-3977
Fax: 407-985-1961

Davenport
108 Park Place Blvd, Ste C
Davenport, FL 33837
Ph: 863-422-1734
Fax: 863-421-1975

Re:_____ Date:_____

To Whom It May Concern:

This authorizes _____ and medical attendants to furnish full and complete medical reports and information request by the undersigned to **Hill Orthopedic Center, LLC.** Or any of its representatives. Especially any and all medical reports concerning treatment I had. This authorization also includes examination of all hospital records, x-ray film and furnishing of any information including opinions which will aid to patient treatment. Your full cooperation with **Hill Orthopedic Center, LLC** is requested. You are further requested not to disclose such information to any other person without written authority to do so.

_____

Date of Birth

_____

Print Name

_____

Sign Name

HILL ORTHOPEDIC CENTER, LLC

Notice of Additional Fee's and Form's:

- There will be a fee of $30.00 for every no show of an office visit with Hill Orthopedic Center.
- There will be a fee of $50.00 for all (NSF) Insufficient Fund checks that are written to Hill Orthopedic Center.
- There will be a fee of $1.00 per page for request of medical records.
- There will be a fee of $25.00 when requesting an imaging CD.
- There will be a fee of $10.00 for every parking permit forms and can take up to 7 business days to complete.
- There will be a fee of $25.00 for all paperwork (i.e. Disability/WC/FMLA etc.) initially and can take up to 7-10 business days to complete. *If you request additional paperwork and/or changes, there will be an additional $10.00 fee.*
- There will be a fee of $250.00 if surgery is cancelled within a two-week period of surgery date.

_____

(Patient Print Name)

_____ _____

(Patient Signature) (Date)

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(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**)*:

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.

HILL ORTHOPEDIC CENTER, LLC

RELEASE OF CONFIDENTIAL INFORMATION

_____ (initial) This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

a) Healthcare providers involved in your care
b) Insurance companies to secure payment
c) Laboratories involved in your care
d) Attorneys with your permission
e) Friends/Family and/or other you specify below

Name	Relationship
_____	_____
_____	_____
_____	_____

_____ (initial) Appointment reminders and any information regarding your treatment may be called to (check below):

- ☐ My home/answering machine
- ☐ My office or voicemail
- ☐ Other: _____

_____ (initial) A copy of "Notice of Privacy Practices" is available for your review. I been given a copy or "Notice of Privacy Practices".

_____
Print Patient Name

_____ _____
Patient Signature **Date**

HILL ORTHOPEDIC CENTER, LLC

ASSIGNMENT OF BENEFITS

I_____, assign all of the right and benefits of any applicable personal injury protection, medical payments, or other coverage provided by any insurance policy issues pursuant to Florida Statutes § 627.730 - §627.7405, to HILL ORTHOPEDIC CENTER, LLC, for services and supplies provided to me related to personal injuries I suffered in an automobile accident which occurred on _____.

I agree to pay any co-payment or deductible not covered by the applicable personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;

All rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and

All rights to recover attorney fees, legal assistant fees, costs and any interest on fees and costs, for any legal or other action taken by HILL ORTHOPEDIC CENTER, LLC as my assignee.

I agree that HILL ORTHOPEDIC CENTER, LLC may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I instruct any insurance carrier for which I have assigned my applicable insurance benefits to notify HILL ORTHOPEDIC CENTER, LLC immediately of any dispute over coverage or payment of benefits, and to reserve benefits at least to the disputed amount.

I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

_____ _____

Patient Name Date

The undersigned, as authorized representative of COMMUNITY THERAPY ASSOCIATES, LLC accepts the assignment of benefits as set forth above.

_____ _____

[Provider] Date

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(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):*

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.

OIR-B1-1571
Pub. 1/2004

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)