Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned licensed medical professional or medical director, as applicable, affirms the statement numbered 1 above and further certifies:

A. I have not solicited, nor caused the solicitation of, the insured individual, involved in a motor vehicle accident, to file a claim for Personal Injury Protection (PIP) benefits.
B. The treatment or services provided to the insured individual, or their guardian, have been adequately explained to ensure informed consent prior to the signing of this form.
C. The accompanying statement or bill has been completed accurately in all material aspects, and all required information has been provided. This ensures that each request for information has been answered truthfully, accurately, and comprehensively.
D. The procedure coding on the accompanying statement or bill is accurate. No services have been upcoded, unbundled, or incorrectly listed as medically unnecessary diagnostic tests, as defined in Sections 627.732(15) and (16), and Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director (if applicable)

Name (Print or Type): _____

Signature: _____

Date: _____

The undersigned insured person (or guardian of the insured) affirms:

1. The services or treatments listed below have been provided. This confirms that the services have already been rendered. Emergency Medical Condition
2. I acknowledge my right and duty to verify that the services have been delivered.
3. I was not solicited by any individual to seek services from the medical provider listed above.
4. The medical provider has thoroughly explained the services for which payment is being requested.
5. If I notify my insurer in writing of any billing discrepancies, I may be entitled to a portion of any reduction in payments made by my motor vehicle insurer. If eligible, my share will be at least 20% of the reduction amount, up to $500.

Fraud Notice:
Any individual who knowingly submits a claim or application containing false, incomplete, or misleading information with the intent to defraud, deceive, or cause harm to any insurer is committing a third-degree felony under Section 817.234(1)(b), Florida Statutes.

Note:
The original copy of this form must be provided to the insurer in accordance with Section 627.736(4)(b), Florida Statutes, and may not be submitted electronically. Failure to submit this form may result in the non-payment of the claim.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Signature: _____

Date: _____

Patient Consent and Authorization

I, the undersigned, acknowledge and agree that I am financially responsible for all charges incurred, regardless of whether my insurance provider pays. In the event that CloudMD is required to engage a collection agency or attorney for payment recovery, I understand that I will be liable for any collection and legal fees associated with such action. I hereby authorize my medical provider to release necessary medical information to my insurance company for the purpose of securing payment of benefits. I further authorize the use of my signature on all insurance claims and direct payment of benefits to CloudMD, located at 3905 NW 107th Ave, Suite 403, Doral, Fl. 33178. I consent to the administration and performance of any medical treatments, procedures, prescribed medications, diagnostic tests, cultures, and laboratory tests deemed necessary or advisable by my attending physician or their designees. This consent is provided in advance of any specific diagnosis or treatment and is intended to be ongoing. I understand that this consent will remain in effect until revoked in writing. I acknowledge that CloudMD will use and disclose my medical information for treatment, payment, and healthcare operations as outlined in the Notice of Privacy Practices. A photocopy of this consent shall be deemed as valid as the original. For Medicare patients, I authorize the release of my medical information to the Social Security Administration or its intermediaries for processing Medicare claims. I confirm that I have received CloudMD's Notice of Privacy Practices and understand that I may contact the Privacy Officials with any questions or concerns. I, the undersigned, voluntarily assign the benefits payable for services rendered to CloudMD. I hereby assign the rights and benefits of my automobile insurance (Personal Injury Protection and Medical Payments policy) to CloudMD, and I understand that this assignment is made in lieu of requiring payment at the time services are provided. This document authorizes CloudMD to pursue legal action against my insurer for the payment of benefits and to seek damages from the insurer under Florida Statute 627.428. I confirm that I have received a copy of CloudMD's Notice of Privacy Practices. I authorize the physicians and staff of CloudMD to communicate with any family or friends I designate in writing regarding my medical care.

I hereby certify that I have read, understood, and voluntarily consent to the terms set forth in this document.

Signed: _____

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider hereby attests to the following:

The patient identified below has been evaluated and, in the opinion of this medical provider, has suffered an **Emergency Medical Condition** as a result of injuries sustained in an automobile accident that occurred on _____ (date of accident).

The basis for this opinion is that the patient has experienced acute symptoms of sufficient severity, including severe pain, such that the failure to provide immediate medical attention could reasonably be expected to result in any of the following: (a) serious jeopardy to the patient's health; (b) serious impairment to bodily function; or (c) serious dysfunction of a bodily organ or part.

I affirm that I am a licensed physician under Chapter 458 or Chapter 459, a licensed dentist under Chapter 466, a licensed physician assistant under Chapter 458 or Chapter 459, or a licensed advanced registered nurse practitioner under Chapter 464, and that the above statements are true and correct.

Name of Medical Provider: _____

Signature of Medical Provider: _____

Date: _____

The undersigned injured person or legal guardian of the injured person asserts:

1. The symptoms I reported to the medical provider are truthful and accurate.
2. I understand that the medical provider has determined that I have sustained an **Emergency Medical Condition** due to the injuries I sustained in the motor vehicle accident.
3. The medical provider has explained to my satisfaction the need for ongoing medical care and the potential harmful consequences to my health if I do not receive the recommended treatment.

Signature of Injured Patient/Guardian: _____

Date: _____

Patient Record Release and Letter of Protection

I hereby authorize CloudMD to release to my attorney, as identified below, all medical records and reports, as well as any charges related to the treatment I have received.

I further authorize the aforementioned attorney to directly pay CloudMD any amounts owed for services rendered, and to withhold such amounts from any settlement, judgment, or verdict that may be awarded to me, my attorney, or any other party as a result of the injury for which I have received treatment. Additionally, I agree to promptly notify CloudMD if I am represented by a new attorney, and to execute a new release and letter of protection with my new attorney, if applicable.

In the event that a new release and letter of protection is not executed upon a change of attorney, I acknowledge that the total outstanding charges will become immediately due and payable.

I fully understand and agree that I am personally responsible for all charges and bills submitted by CloudMD for services rendered. This agreement is made solely for the additional protection and consideration of awaiting payment. I further understand that payment for these services is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said amounts.

Date of Incident: _____

Attorney's Name: _____

Patient's Signature: _____

Date: _____