

**HOPKINS CLINIC**  
**6231 - 66<sup>th</sup> STREET NORTH**  
**PINELLAS PARK, FLORIDA 33781**  
**TELEPHONE (727) 544 - 3330    FACSIMILE (727) 544 - 3221**

Having been accepted as a patient at Hopkins Clinic, (hereafter also called THE OFFICE), I understand and agree to the following conditions of acceptance:

1. **CONSENT TO TREATMENT:** I give THE OFFICE permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures as they may deem necessary in the diagnosis and/or treatment of my (their) condition. I give the doctors and staff permission to treat and touch me. My signature below verifies my full understanding of this consent and, upon my request, any possible risks regarding the treatment will be explained to me. I acknowledge THE OFFICE has made no guarantee or assurance as to any results I may obtain from services received.

2. **NOTIFICATION OF CHANGES:** I will immediately notify THE OFFICE of changes in my health status, home and work telephone numbers, mailing address, insurance benefits, attorney representing me in a personal injury law suit, and any information I have given on the patient intake forms.

3. **RELEASE OF INFORMATION:** To the extent necessary to determine liability for payment and obtain reimbursement, I authorize THE OFFICE to furnish, upon written request authorized by me, any information in my medical record including photographs or computer images to any and all persons or organization which are or may be liable for all or any portion of my medical charges at THE OFFICE. I authorize THE OFFICE to release any information pertinent to my case to any insurance company or their representative involved in this case.

4. **FILING INSURANCE CLAIMS:** As a courtesy and at my request for THE OFFICE to accept delayed payment for my care, THE OFFICE will submit insurance claim forms for payment of my medical benefits. I authorize THE OFFICE to submit claims for each service rendered and charge usual, reasonable and customary charge in this area for each service.

5. **ATTORNEY LIEN:** In the event I receive medical payment benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or other reimbursement from any settlement, judgment or verdict on my behalf, I hereby authorize and direct my attorney to FIRST PAY THE OFFICE directly the amount due for services rendered before any other disbursements are made from any funds received by the attorney's office on my behalf. This attorney lien is binding on any and all attorneys involved in my case prior to and subsequent to the date of this agreement with THE OFFICE. I may only revoke this lien by a certified letter received at THE OFFICE. I also give power of attorney to THE OFFICE to endorse/sign my name on any check received in my name for services rendered and owing THE OFFICE.

6. **GUARANTEE OF PAYMENT:** I understand and agree I am personally responsible for all services received at THE OFFICE, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgment or verdict on my behalf. I understand if my account at this office is past 60 days overdue, it may be subject to a 1.5% per month (18% per year) finance charge. If the defaulted amount is referred to a collection agency and/or for legal action I agree to pay for reasonable court costs and other costs of collection.

## ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of HOPKINS CLINIC to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to HOPKINS CLINIC the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by HOPKINS CLINIC.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by HOPKINS CLINIC, is hereby directed to issue payment for those benefits directly to and payable to HOPKINS CLINIC.

I also authorize and assign to HOPKINS CLINIC the right to file suit and pursue all legal remedies to obtain payment for services provided to me by HOPKINS CLINIC. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by HOPKINS CLINIC and includes the assignment to pursue declaratory relief or any other legal remedies.

HOPKINS CLINIC accepts the aforesaid assignment and hereby notifies any insurer issuing payment that HOPKINS CLINIC objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to HOPKINS CLINIC a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to HOPKINS CLINIC a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by HOPKINS CLINIC have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by HOPKINS CLINIC, or made payment to HOPKINS CLINIC at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify HOPKINS CLINIC that benefits have

been exhausted except for the amount held in escrow, to enable HOPKINS CLINIC to attempt to resolve the disputed claim in a manner acceptable to HOPKINS CLINIC.

**DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY:** I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

**AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER:** I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to HOPKINS CLINIC upon the request of HOPKINS CLINIC. This authorization includes the authorization to release to HOPKINS CLINIC a copy of any medical examination or evaluation of me requested by any insurance company.

**DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO:** I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to HOPKINS CLINIC of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

**A photocopy of this agreement shall be considered as effective and valid as the original.**

\_\_\_\_\_  
Patient's signature (or guardian's signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to patient or guardian's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized signatory for medical provider

\_\_\_\_\_  
Date