

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____
Contact Phone: _____ Email: _____
Address: _____

MELANIE CROSS, MD • 956 International Parkway, Suite 1580 • Lake Mary, FL 32746
Ph (407) 721-2127 • Fax (407) 936-0316 •

LAKE MARY MEDICAL SERVICES PI PATIENT INTAKE FORM

Medical History/Review of Systems (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Latex, Food, or Medication (specify): | |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Hernia(s) or Hernia Repair |
| <input type="checkbox"/> Anxiety and/or Depression | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint Pain, Swelling, or Stiffness |
| <input type="checkbox"/> Asthma or Breathing Difficulties | <input type="checkbox"/> Joint Replacement and/or Metal Implants |
| <input type="checkbox"/> Blood Pressure (specify): High Low | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Osteopenia or Osteoporosis |
| <input type="checkbox"/> Circulatory Disorder or Peripheral Vascular Disease | <input type="checkbox"/> Pregnant and/or Breastfeeding (currently) |
| <input type="checkbox"/> Defibrillator or Pacemaker | <input type="checkbox"/> Parkinson 's Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Fainting/Dizziness/Vertigo | <input type="checkbox"/> Seizure(s) |
| <input type="checkbox"/> Fever or Night Sweats | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Smoker (current) |
| <input type="checkbox"/> Headaches or Migraines | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Spinal Disk Herniation |
| <input type="checkbox"/> Heart Disease and/or Heart Attack | <input type="checkbox"/> Spinal Fusion |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disorder |

Reproductive Health History (IF applicable):

Date of last menstrual period (or indicate if post-menopause): _____

I acknowledge that the health history information provided above is accurate to the best of my knowledge.

Signature: _____

Date: _____

Office of Insurance Regulations
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 the relevant information has been provided therein. This means that each request for information has been 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)7, 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)(9b), 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.

LAKE MARY MEDICAL SERVICES

▪ PI AUTHORIZATION FOR TREATMENT ▪

▪ PI RELEASE OF RECORDS ▪

▪ PI ATTORNEY REPRESENTATION ▪

AUTHORIZATION FOR TREATMENT:

I, the undersigned, a patient of Lake Mary Medical Services hereby authorize Lake Mary Medical Services to administer treatment for the purpose of pain management, medication management for anxiety or sleep disturbance as needed. I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities, approximate length of care, and that consent can be revoked orally or in writing prior to or during the treatment period. I have read and fully understand this authorization for treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

RELEASE OF RECORDS:

I hereby authorize Lake Mary Medical Services to release to any attorney, physician, or insurance company, involved in my case, any medical records or other information necessary to process my claim, which will be utilized for the ultimate recovery of benefits related to my injury/illness sustained on or about (date) _____.

ATTORNEY REPRESENTATION FOR AUTO INJURY:

I hereby authorize and direct you, my attorney, to pay Lake Mary Medical Services from any settlement, judgement, or verdict for any unpaid balances due as the result of services rendered to me related to treatment of injuries, including court time, and/or any costs related to collection attempts related to treatment of injuries sustained by me on (date): _____.

My signature below indicates I have read the above statements regarding authorization for treatment, assignment of benefits, release of records, and attorney representation and agree to abide by them.

Print Name: _____ Date: _____

Signature: _____

LAKE MARY MEDICAL SERVICES PI RECEIPT OF PRIVACY NOTICE

My signature, below, certifies I have received or reviewed a copy of the NOTICE OF PRIVACY PRACTICES.

Printed Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

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LAKE MARY MEDICAL SERVICES, L.L.C
ASSIGNMENT OF BENEFITS

In exchange for medical services, I hereby assign and transfer any and all insurance policy rights, benefits, and causes of action to Lake Mary Medical Services, L.L.C. for services rendered by Lake Mary Medical Services, L.L.C. related to the automobile incident which occurred on or about _____.

This is an assignment of my rights and benefits. I authorize the insurance company to issue payment directly to Lake Mary Medical Services, L.L.C. I also authorize the insurance company to release any information about my policy and claim directly to Lake Mary Medical Services, L.L.C.

Print Name _____

Signature _____

Date: _____

MELANIE CROSS, MD, 956 INTERNATIONAL PARKWAY SUITE 1580 LAKE MARY, FL 32746
PH 407-721-2127 FAX 407-936-0316

LAKE MARY MEDICAL SERVICES

Below are the telephone numbers that must be posted by each licensed FQA facility to comply with CORE 408.801(5)(a)1. And 2. See statute below.

The complaint number is our agency toll free # 1-888-419-4356

The abuse line is 1-800-96-ABUSE (962-2873)

408.810(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "to report a complaint regarding the services you receive, please call toll free 1-888-4119-3456"
2. Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "to report abuse, neglect or exploitation, please call toll free 1-888-96-ABUSE (962-2873)." The agency shall publish a minimum.

LAKE MARY MEDICAL SERVICES PI PAIN MANAGEMENT PATIENT AGREEMENT

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances.

____ I understand that this Agreement is important to the trust and confidence needed in a doctor/patient relationship and that my doctor agrees to treat me based on this Agreement.

____ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. They will taper off my medicine over a period of a few days to avoid withdrawal symptoms and refer me to a drug-dependence treatment program.

____ I will be agreeable to seeking mental health (psychiatric or psychological) treatment if my doctor thinks it necessary.

____ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

____ I will not use illegal controlled substances including Cocaine, MDMA, and amphetamines. Nor will I misuse or self-prescribe legal controlled substances. The use of alcohol is to be AVOIDED, especially when driving/operating machinery.

____ I will not share my medication with anyone. I will keep my medications safe from loss, theft, or unintentional use by others. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED!

____ I will not try to get any controlled medications, including opioid pain medications, or any anti-anxiety medications from any other provider and understand that refills of my prescriptions for pain medications will be made ONLY at the time of an office visit.

____ I authorize my doctor and pharmacy to cooperate fully with any law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication.

____ I agree that I will do a blood or urine test when requested by my doctor, without delay or evasion, to check on my compliance with my pain management program.

____ I understand that my doctor will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program Website regularly throughout my treatment.

____ I agree to not use my medicine faster than my prescribed rate and that use of my medicine at a faster rate will lead to me being without medication for a period of time.

____ I understand that medication(s) prescribed for pain can be addicting and should be taken ONLY as directed and that these medications have increased risk of side effects and potentially deadly interactions (especially with alcohol and sedatives).

____ I AGREE TO FOLLOW THESE GUIDELINES THAT HAVE BEEN FULLY EXPLAINED TO ME. All my questions and concerns regarding my treatment have been adequately answered document.

This agreement is entered into this ____ day of _____, 20____.

Patient Name: _____ Patient Signature: _____

Provider Name: Melanie Cross, M.D. Provider Signature: _____

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