

CENTER FOR Neuroscience

NEUROLOGY • PSYCHOLOGY • NEUROPSYCHOLOGY

Patient Information:

Today's Date: _____

Name: _____

Date of Birth: _____

Social Security Number: _____

Marital Status: _____ Gender: _____

Street Address: _____

City/ State / Zip Code: _____

Phone # _____ Cell # _____

E-mail Address: _____

Which of the following **languages** can you speak and/or understand? Please circle:

English Spanish Creole French Portuguese Hindi/Urdu

Ethnicity: Non- Hispanic/Latino _____ **Race** (circle) Caucasian African-American Hispanic
Hispanic/Latino _____ Indian Oriental Other _____

Employer: _____

Employer Phone No.: _____

Emergency Contact: _____

Contact Phone No.: _____

Name of Caregiver / Guardian: _____ Phone No.: _____

Purpose of Visit (please circle): Neurological Evaluation Diagnostics

Physical Rehabilitation Neuropsychological Evaluation/ Psychological Therapy

Insurance Information:

Name of Insurance Company: _____

Policy and or Claim Number: _____

Date of Accident or Injury (if applicable): _____ **Auto Accident or Worker Compensation**

If your visit is accident or injury related, have you done the following?

Do you have an attorney? Yes No

Name of your attorney: _____

Patient's Signature

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HISTORY OF PRESENT ILLNESS:

Please describe your main problem or reason for making an appointment _____

When did symptoms begin? _____ Have you been treated for this problem before? Yes No

If yes, please describe the treatment you received including dates:

PAST MEDICAL HISTORY

PROBLEM / DATE

PAST SURGICAL HISTORY (Please list)

SURGERY/YEAR

_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS:

List all medications you are currently taking: (include non-prescription and occasionally used medicines).

Current medication

Dosage/ Time taken

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all psychiatric medicines you have been prescribed in the past (including anti-depressants, anti-anxiety, anti-psychotics or medications used to help you sleep).

Medication Name

Dates

How long you took it

Side Effects

_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for a mental/ psychiatric illness? If so, please list dates and hospital:

ALLERGIES (List any medication, food or other allergies):

Do you have a pacemaker? Yes No

FAMILY HISTORY:

Please use the space below to list all of your immediate family (parents, siblings, and children).
Under illnesses, please list serious illnesses or diseases, especially psychiatric/mental illness.

<u>RELATIONSHIP</u>	<u>AGE</u>	<u>ILLNESS/ CAUSE OF DEATH</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN:

_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Married _____ Divorced _____ Widowed _____

Number of Children _____

Birth state and where you were raised: _____

Education Level: High School Graduate _____ Some College _____ College Graduate _____

Degrees: _____

Employment Status: employed _____ Unemployed _____ Retired _____ Student _____

Smoking: Currently smoking _____ Former smoker _____ number of years: _____ Never smoked _____

Alcohol History: Never drinks _____ Currently drinks _____

Alcohol: approximate drinks per week: _____

Exercise: type: _____ frequency: _____

Hobbies, interests: _____

Are you currently driving? _____

Living Arrangements: With whom do you live? _____

_____ Home

_____ Assisted living

_____ Nursing home

Is there any other information you want to make us aware of? _____ \

PAST MEDICAL/ FAMILY HISTORY

Please list any serious illness or ongoing medical problems since childhood. Include any surgical procedures::

Conditions	Self	Father	Mother	Siblings	G-parent	Other
Asthma						
High blood pressure						
Diabetes						
Heart disease						
Arrhythmia						
Cancer						
High cholesterol						
Stroke/ TIA						
COPD						
Chronic bronchitis						
Emphysema						
Seizures						
Dementia						
Alzheimer's disease						
Parkinson disease						
Huntington's disease						
Gastritis						
Ulcers						
Thyroid disease						
Liver disease/ Hepatitis						
HIV/ AIDS						
Sinusitis						
Kidney disease						
Head/ Brain injury						
STD						
Reflux Esophagitis						
Glaucoma						
Macular Degeneration						
Cataracts						
Headaches/ Migraine						
Miscarriages/ stillbirth						
Vertigo						
Tremors						
Multiple Sclerosis						
Birth/ Developmental Problems						
Hypoxia						
Depression						
Anxiety Disorder						
Schizophrenia						
Bipolar Disorder (Manic Depression)						
Obsessive Compulsive Disorder						
ADD/ADHD						
Learning Disability						
Post Traumatic Stress Disorder						
Other:						

REVIEW OF SYMPTOMS: Please check any of the following that pertain to you
Give dates, duration of symptoms and details when applicable.

CONSTITUTIONAL

- Lack of energy or fatigue _____
- Loss of appetite _____
- Difficulty sleeping _____
 - Awake early and can not return to sleep
 - Have trouble falling asleep

EYES

- Eye pain _____
- Blurred or double vision _____
- Sensitive to glare _____

EARS/NOSE/THROAT/NECK

- Problems with sense of smell _____
- Problems with taste _____
- Problems with hearing _____
- Uses hearing aid _____

CARDIOVASCULAR

- Chest pain _____
 - At rest _____
 - With activity _____
- Swollen ankles _____
- Palpitations or heart racing _____
- High blood pressure _____
- High cholesterol _____

RESPIRATORY:

- Cough _____
- Asthma or wheezing _____
- Become short of breath when walking or with activity _____

GASTROINTESTINAL:

- Problems swallowing _____
- Burning in chest or stomach after meals or when lying down _____
- Constipation _____
- Diarrhea _____
- Change in color of stool/ black or tarry stools? _____

GENITAL/ URINARY:

- Delayed ejaculation _____
- Difficulty holding in urine _____
- Difficulty maintaining an erection _____
- Difficulty urinating _____
- Frequent urinary tract infections _____
- Loss of interest in sex _____
- Need to urinate more frequently _____
- Pain when urinating _____
- Pain with intercourse _____
- Pain with intercourse _____

MUSCULOSKELETAL:

- Back pain _____
- Difficulty standing up from sitting _____
- Neck pain _____
- Other pain _____
- Pain greater in the morning and decreases with activity _____
- Stiffness or pain in joints _____

NEUROLOGICAL:

- Confusion _____
- Difficulty finding your way _____
- Difficulty maintaining home _____
- Difficulty managing finances _____
- Difficulty speaking _____
- Dizziness or fainting _____
- Feels dizzy when stands up _____
- Forgetfulness _____
- Head trauma _____
- Headaches or migraines _____
- Numbness or tingling in toes and fingers _____
- Problem with balance _____
- Recent fall or falls frequency _____
- Seizure or fits _____
- Sleep problems such as loud snoring, gasping for breath, morning headaches,
daytime sleepiness or leg jerking _____
- Tremor or difficulty writing _____

PSYCHIATRIC

- Anxious, restless ,or irritable _____
- Crying Spells _____
- Depression , persistent sadness or feeling blue _____
- Difficulty concentrating _____
- Feelings of hopelessness or worthlessness _____
- Hallucinations _____
- Hearing voices _____
- Loss of pleasure in life _____
- Paranoia _____
- Thoughts of hurting someone else _____
- Thoughts of suicide _____

ENDOCRINE:

- Cold intolerance _____
- Dry Skin _____
- Hair loss or coarse hair _____
- Heat intolerance _____
- Hoarse Voice _____
- Thyroid disease _____
- Weight gain or loss _____

ACTIVITIES OF DAILY LIVING

IF THERE ARE NO PROBLEMS WITH ACTIVITIES OF DAILY LIVING PLEASE SKIP TO PAGE 11

PLEASE DESCRIBE HOW MUCH HELP IF ANY YOU NEED WITH EACH OF THE FOLLOWING ACTIVITIES. CHECK THE MOST APPROPRIATE ANSWER BELOW:

EATING:

- Eat without assistance (plans meals, cooks, feeds self, cleans) _____
- Eat with minor assistance at meal times (e.g. preparing food) _____
- Eat with moderate assistance (e.g. planning and cooking) _____
- Need extensive assistance for all meals _____
- Cannot feed self at all _____

DRESSING:

- Dresses/ undresses and selects clothes without assistance _____
- Dresses/ undresses with minor assistance _____
- Needs moderate assistance in dressing or selection of clothes _____
- Needs major assistance in dressing _____
- Completely unable to dress and resists help _____

GROOMING: (combing hair, shaving)

- Always neatly dressed and well groomed without assistance _____
- Grooms adequately with occasional minor assistance _____
- Needs moderate and regular assistance or supervision _____
- Needs total grooming care but remains well-groomed after getting help _____
- Resists efforts to help maintain grooming _____

BATHING:

- Bathes in tub/shower or takes sponge bath without assistance _____
- Bathes self but needs help getting in and out of tub/shower _____
- Washes face/hands but cannot bathe rest of body _____
- Does not wash self but is cooperative with help _____
- Does not try to wash self and resists help _____

TOILETING:

- Cares for self at the toilet completely and no incontinence _____
- Needs reminders or help cleaning self or may have rare accidents _____
- Soils or wets clothes while asleep _____
- Soils or wets clothes while awake _____
- Has little or no control over bladder or bowels _____

WALKING:

- Walks around neighborhood or city alone _____
- Ambulates in home or within one block from home alone _____
- Ambulates well with assistance of another person, or alone using _____
- Railing, cane, walker, wheelchair _____
- Sits unsupported in chair or wheelchair, but can't ambulate without help _____
- Bedridden more than half the time _____

TRAVELING:

- Travel independently on public transport or drives own car _____
- Arranges own travel by taxi but does not use public transportation _____
- Travels using public transportation when assistance of another person _____

FINANCES:

- Manages financial matters independently _____
- Manages day-to-day purchases but needs help with banking _____
- Or major purchases _____
- Incapable of handling money _____
- Does not apply _____

TELEPHONE:

- Operates the telephone on own initiative _____
- Dials only a few well know numbers _____
- Answers telephone and takes messages but doesn't dial _____
- Answers telephone but cannot take messages and does not dial _____
- Does not apply _____

FOOD PREPERATION:

- Plans, prepares, and serves adequate meals independently _____
- Prepares adequate meals if supplied with ingredients _____
- Heats and serves prepared meal or prepares simple meals but _____
- Does not maintain an adequate diet _____
- Needs to have meals prepared and served _____
- Does not apply _____

HOUSEKEEPING:

- Maintains own house alone or with occasional assistance _____
- Performs only light daily tasks _____
- Performs light daily tasks but cannot maintain an acceptable _____
- Level of cleanliness _____
- Does not participate in any housekeeping tasks _____
- Does not apply _____

SHOPPING:

- Takes care of all shopping needs independently _____
- Shops independently for small purchases _____
- Needs to be accompanied on any shopping trip _____
- Completely unable to shop _____
- Does not apply _____

MEDICATIONS:

- Independently takes medication correctly _____
- Takes responsibility for taking medications if prepared in _____
- Advance in separate doses _____
- Not capable of dispensing own medication _____
- Does not apply _____

DRIVING:

- Drives alone safely _____
- Drives alone but has had one or more recent accidents _____
- Drives alone but has gotten lost _____
- Drives only with someone else in the car _____
- No longer drives _____

Authorization for Medical Records and Reports

Date: _____

To: _____

You, and any person associated with you, are hereby authorized to give to Center for Neuroscience or any representative thereof any and all information which may be requested regarding my physical condition and treatment rendered by you thereof, and if necessary to allow them, or any physician appointed by them, to examine and X-Ray pictures/ CT or MRI scans/ electro-diagnostics of me, or records which may have information regarding my condition or treatment.

Please Provide the Names and Phone Numbers of your physicians that you would like to have your records forwarded :

PRIMARYCARE _____

INTERNIST _____

OTHER _____

Patient's Signature: _____

Print Name: _____

DOB: _____

SS: _____

Witness' Signature: _____

Authorization for Release of Insurance Information

Date: _____

To: _____

You, and any person associated with you, are hereby authorized to give to The Center for NeuroScience or any representative thereof any and all information which may be requested regarding insurance claim information for your clients P.I.P. claim. Clients name in order to process any foregoing claims acquired by the patient.

Patient's Signature _____

Print Name: _____

DOB: _____

SS#: _____

Witness' Signature: _____



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Conditions for Admission

Medical Consent: The undersigned consents to any X-Ray, examinations, and/or medical services rendered to the patient under the general and special instructions given by the physician.

Minors: If the patient is a minor or an incapacitated person, the undersigned hereby consents for any medical procedure on his/her behalf which the physician may consider necessary in the treatment of his/her care.

Liability: The patient is under the care of the Center for NeuroScience. Neither Dr. Siddiqui nor Dr. Joyce is liable for any act or omission in following the instructions given by Dr. Siddiqui or Dr. Joyce.

Personal Valuables: It is agreed and understood that the medical practice of the Center for NeuroScience shall not be liable for the loss of and/or damage to any personal property items (i.e. money, jewelry, dentures, documents, garments etc.).

Payment: The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, the Center for NeuroScience may disclose portions of patient's medical records, to any person or corporation which is or may be liable for all or any portion of the charges for services provided the Center for NeuroScience.

If your account is delinquent at 60 days, 25% collection fee, will be added to the amount due.

Patient's Signature

Printed Name

Direction of Payment

I authorize the Center for NeuroScience to release any information acquired in the course of my examination to my insurance company. I hereby authorize payment directly to the Center for NeuroScience of the medical benefits, if any, otherwise payable to the provider for services not to exceed the provider’s usual and customary fee. I also authorize the refund of over paid insurance benefits where my coverage is subject to a coordination of benefits. I recognize, understand and accept that I am financially responsible to the provider for all charges for any unpaid balance or fee not covered, In the event that I have no insurance or my insurance coverage is to pay the legal rate of interest on the account until paid in full and hereby waive all rights of exemption under the constitution and the laws of the State of Florida.

I agree that the Center for NeuroScience be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor’s bills when sent directly to their office.

I request that payment of authorized medical benefits be made on my behalf to the Center for NeuroScience for any services furnished to me by the physician or his employee. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits payable for related services.

Name of Insurance Company

Name of Insured

Insurance Claim / I.D. Number

Patient’s Full Name Printed

Patient’s Signature (Parent or legal guardian if patient is a minor)

Center for NeuroScience Policy Regarding No-Shows

It is the policy of Center for NeuroScience that patients who do not attend a scheduled appointment (or fail to cancel within one full business day prior to the scheduled appointment) will be charged a no-show fee of \$50.00 for each hour scheduled.

Patricia M. Joyce Ph.D.
Director, Center for NeuroScience

Samuel F. Siddiqui, MD, MPH
President, Center for NeuroScience

I agree to pay a no-show fee of \$25.00 for every scheduled hour with Dr. Joyce and Dr. Siddiqui that I failed to attend or cancel within one full business day prior to the appointment. I give express permission to the Center for NeuroScience to charge my credit card, on file, for the appropriate amount.

Patient's Name (please print)

Signature

Date



NEUROLOGY • PSYCHOLOGY • NEUROPSYCHOLOGY

E-Prescribing Consent Form

Patient's Name _____

Center for Neuroscience is in the process of implementing ePrescribing:

- ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011
- ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

Patient Consent:

I agree that Center for Neuroscience may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent form will be updated on an annual basis.

Please provide our office with your pharmacy name, address, phone number/ fax number

Pharmacy Name: _____
Address: _____
Ph#: _____ - _____ - _____
Fax#: _____ - _____ - _____

_____/_____/20_____
(Patient Signature) Date

NOTICE of PRIVACY PRACTICES

I, _____ acknowledge that I have received the
Notice of Privacy Practices.

Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

Claim No: _____

Adjuster: _____

The undersigned patient hereby assigns the benefits of insurance under the applicable automobile policy

to: Doctors' name: _____ at

the **Center For Neuroscience** for service rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage under the policy issued to:

(Insured's' Name): _____

and in accordance with Florida Statute 627.736 (5)

The undersigned patient further agrees to pay any co-payment and/or deductible not covered by the aforementioned PIP coverage. The undersigned patient agrees to permit the **Center for Neuroscience** to obtain access to the PIP payment log to assist in identifying eligibility and benefit information.

Patient Signature

Date

Print name here: _____

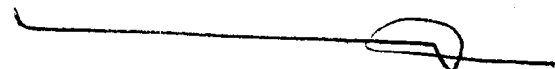
The undersigned hereby accepts assignments of insurance benefits for service rendered to:

(Patient's Name): _____
with such benefits to be paid directly to me under:

(Insured's Name): _____'s

Personal Injury Protection coverage with _____ and in

Accordance with Florida Statute 627.336(5)



Physician Signature

Date

Print Name here: _____

(New Patient Injury History)

Name: _____

Today's Date: _____

Age: _____

Date of Accident: _____

Handedness: (Please circle) Right _____ Left _____ Ambidextrous (Both hands) _____

About what time of day did the accident occur? _____

Was your seat belt on at the time of the accident? _____

Did the air bags deploy? _____ YES _____ NO

Were you the driver? _____

If not, where were you in the vehicle? _____

(Please circle) At the time of impact-were you at a traffic light? (yes or no)or stop sign? (yes or no)

Were other cars stopped in front of you? (Yes or no)

Was your car first in line at stop sign/traffic light? (Yes or no)

If your car was moving upon impact, were you: (Circle one) slowing with stop & go traffic? (yes or no)

Slowing for other reasons? (Yes or no) Traveling at a steady pace? road w/ multiple lanes? (yes or no)

Do you recall what happened to you upon impact? (Yes or no)

Please describe: _____

Did your head hit dashboard / steering wheel / windshield in front of you? (yes or no)

Did you hit the headrest behind you? (Yes or no / don't remember)

Did you lose consciousness as a result of the accident? (Yes or no) If yes for how long? _____

Immediately after impact how did you feel? Dazed / Confused / Anxious

Did you have any pain at the scene of the accident? (Yes or no)

If not,
when did the pain appear after the accident? _____

Did you go hospital by ambulance from the scene? (Yes or no)

Which hospital? _____

Were you admitted or discharged the same day? (Yes or no)

Did you see any other practitioners for your accident related injuries? (yes or no) If so, who & where?

Who else have you seen related to your accident?

Name & type of practitioner? _____

Have you been able to work since the accident? (yes or no)

If not, specify dates unemployment _____

If working, have you missed any days of work as a result of the accident & your injuries? (yes or no)

Symptoms caused by this accident (please circle all that apply)

Headaches Neck pain Back Pain Shoulder pain Knee pain Arm pain Leg pain

Have you had any of the following diagnostic tests done since the accident?

X-rays Neck Back Head Other (please specify)

MRI Scan Neck Back Head Other (please specify)

CAT Scan Neck Back Head Other (please specify)

Nerve Study Arms Legs

If you have headaches please complete the following:

Where on the head are the headaches located? (Circle all that apply)

Front Back Top Temples...left right both

Are the headaches one-sided or on both sides of the head?

One-Side Right Left (circle one)
Both Sides _____ YES _____ NO

When do you usually get headaches?

Morning Afternoon Evening During sleep No particular time

Are your headaches preceded by aura? (Shining lights, zigzag lines, blind spots, numbness or tingling in relation to the headaches) _____ YES _____ NO

Are headaches accompanied by the following?

Nausea _____ YES _____ NO vomiting _____ YES _____ NO

Light sensitivity _____ YES _____ NO Noise sensitivity _____ YES _____ NO

Does activity of any kind (housework, office work, etc.) make the headache worse? _____ YES _____ NO

UNTREATED how long does the headache last? (on average)

Less than 30 min. 30 min. – 6 hours 6-24 hours all day

How often do you get headaches? (Circle one)

Several times a day once a day several times a week a few times a month

What is the quality of your headaches? (Circle all that apply)

Aching dull burning sharp throbbing/pounding pressure

Did you have similar headaches prior to the current injury? _____ YES _____ NO

What works for your headaches?

Over the counter medicines (Aspirin, Tylenol, Excedrin) Prescription medicines Other Nothing

How often do you take any medicine for your headaches?

Several times a day Once a day Several times a week Once a week A few times a month

Do you have any immediate family member (first degree relative) with migraines? _____ YES _____ NO

Does your headache get worse or caused by turning your neck? _____ YES _____ NO

If you have back pain please complete the following? (Otherwise skip this section)

How Severe? _____ MILD _____ MODERATE _____ SEVERE

How Frequent? _____ Everyday _____ A few times a week _____ A few times a month

What makes it worse?

Bending forward Bending backward Bending sideways Standing Sitting

Lying down Straining with bowel movement Other (please specify) _____

Does the back pain radiate into your legs? _____ YES _____ NO

If yes, (circle one) _____ Right _____ Left _____ Both

If you have neck pain please complete the following. (Otherwise skip this section)

How severe? _____ MILD _____ MODERATE _____ SEVERE

How Frequent? _____ Everyday _____ A few times a week _____ A few times a month

What makes it worse? _____ Turning the neck _____ Straining with bowel movements _____ Exertion

Other (please specify) _____

Does your neck pain radiate into your arms? _____ YES _____ NO

If yes, (circle one) _____ Right _____ Left _____ Both

Center for Neuroscience

FOR OFFICE USE ONLY

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms & Rates

Insurance: _____

Clm#: _____

Standard Disclosure and Acknowledgement Form
PIP-Initial Treatment or Service Provided

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

- 1. Services 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.

The undersigned licensed medical professional 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. I have explained the services rendered 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.
D. The coding of procedures on the accompanying statement or bill is proper.

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

Name (PRINT or TYPE) Signature Date

Licensed Medical Professional Rendering Treatment (Signature by his or her hand)

[Handwritten signature]

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 info is guilty of a felony of the 3rd 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.

PATIENT: _____ DOA: _____ ATTORNEY: _____

I hereby authorize the above-mentioned doctor(s) to furnish you, my attorney, a full report of his/their examination, evaluation, diagnosis, treatment, prognosis, etc. of me in regard to findings related to the above-referenced accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to Center for NeuroScience, PL, such sums as may be due and owed to the above-mentioned doctor(s) for professional services rendered to me both by reason of the above-referenced accident at the time of any resolution, settlement, and/or judgment of the claim and/or litigation arising from said accident. I further authorize and direct my attorney to withhold such sums from any and all settlements, judgments, and/or other payments as may be necessary to fully protect the interests of said doctor(s). I hereby further give a lien on any proceeds collected and/or paid in regard to my claim and/or lawsuit to Center for NeuroScience, PL, against any and all proceeds of any and all settlements, judgments, and payments which may be paid to me as a result of claims arising from the above-referenced accident. Except that, as the sole and only exception to a lien on the proceeds of my case are the fees and costs due my attorney as a result of any settlement judgment or verdict obtained by my attorney.

I fully understand and agree that I am directly and fully responsible to said doctor(s) for all professional bills submitted by him/them for services rendered to me and that this agreement is made solely for the additional protection of the doctor(s) and in consideration of his/their waiting for payment. I also understand that my responsibility for said bills is not contingent upon my receipt of any and/or adequate compensation in the claim and/or litigation arising out of the above-referenced accident.

I further understand and agree that the doctors, upon my request, may bill my insurance carrier(s) for services provided to me and/or on my behalf. If the sums received by the doctor from my insurance carrier(s) are not sufficient to pay the doctors' charges in full, the outstanding balance owed to the doctor will be subject to all of the terms set forth above. I fully understand and agree that the doctor(s) is not required to accept the insurance payment(s) as full and final settlement of the outstanding balance.

PATIENT'S SIGNATURE: _____ **DATE:** _____

The undersigned, being attorney of record for the above-named patient, does hereby agree to abide by all of the terms set forth above and to withhold and pay to Center for NeuroScience, PL, such sums from the proceeds of any and all payments, settlements, and/or judgments arising from the above-referenced accident as may be necessary to fully protect and compensate the above-mentioned doctor(s) for all services rendered to or on behalf of the above-referenced patient. This agreement shall be governed and construed in accordance with the laws of the state of Florida without giving effect to choice of law doctrines.

The patient agrees that in the event that a legal suit or outside collections are necessary to enforce payment of an unpaid invoice owed by patient, patient agrees for all collection fees and/or attorney's fees, and court costs.

This written agreement represents the entirety of the agreement of the parties and supersedes all previous oral and written agreements between the parties and constitutes the only and entire understanding to exist between the parties with respect to the subject matter of this agreement. No amendment or modification shall be binding unless in writing and duly executed by the parties.

ATTORNEY'S SIGNATURE: _____ **DATE:** _____