

Patient Information:

Name: _____ Today's Date: _____

Social Security Number: _____ Marital Status: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____ Cell No.: _____

E-mail Address: _____

Employer: _____ Employer Phone No.: _____

Employer's Address: _____

Emergency Contact: _____ Contact Phone No.: _____

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

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

English Spanish Creole French Portuguese Hindi/Urdu

Purpose of Visit (please circle):

Neurological Evaluation Physical Rehabilitation Chiropractic Care

Diagnostics Neuropsychological Evaluation Neuropsychological Therapy

Other: _____

Referring Physician Information:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Insurance Information:

Name of Insurance Company: _____

Policy and or Claim Number: _____

Date of Accident or Injury (if applicable): _____

Insurance Company's Address: _____

Deductible Amount: _____ Has your deductible been met? Yes No

Do you have Medicare? Yes No Medicare Number: _____

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

1. Reported the accident to your insurance company? Yes No
2. Has your claim been set up? Yes No
3. Do you have an attorney? Yes No

If you answered yes to question #3, name of your attorney: _____

Patient's Signature

Date

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/ 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:						

PAST SURGICAL HISTORY (Please list)

Surgery	Year
_____	_____
_____	_____
_____	_____

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).

<u>Medication Name</u>	<u>Dates</u>	<u>How long you took it</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

CURRENT MEDICATIONS:

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

Current medication

Dosage/ Time taken

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Do you have a pacemaker? Yes No

PAST MEDICAL HISTORY

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

DATE

PROBLEM

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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.

RELATIONSHIP

AGE

ILLNESS/ CAUSE OF DEATH

_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN:

_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Birth state and where you were raised: _____

Years of education: _____

Degrees: _____

Married _____ Divorced _____ Widowed _____

Occupation (s) prior to retiring: _____

Smoking number of years: _____

History of alcohol abuse or addiction: _____

Alcohol: approximate drinks per week: _____

Exercise: type: _____ frequency: _____

Hobbies, interests: _____

With whom do you live? _____

_____ Home

_____ Assisted living

_____ Nursing home

Are you currently driving? _____

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

REVIEW OF SYMPTOMS:

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

- Depression , persistent sadness or feeling blue _____
- Loss of pleasure in life _____
- Crying Spells _____
- Lack of energy or fatigue _____
- Loss of appetite _____
- Difficulty sleeping _____
 - Awake early and can not return to sleep
 - Have trouble falling asleep
- Difficulty concentrating _____
- Anxious, restless ,or irritable _____
- Feelings of hopelessness or worthlessness _____
- Thoughts of suicide _____
- Thoughts of hurting someone else _____
- Hallucinations of hearing voices _____
- Paranoia _____

HEART DISEASE:

- Chest pain _____
 - At rest _____
 - With activity _____
- Swollen ankles _____
- Become short of breath when walking or with activity _____
- Palpitations or heart racing _____
- High blood pressure _____
- High cholesterol _____
- Dizziness or fainting _____

NEUROLOGICAL:

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

SENSATIONS:

- Problems with sense of smell _____
- Problems with taste _____
- Problems with hearing _____
- Uses hearing aid _____
- Eye pain _____
- Blurred or double vision _____
- Sensitive to glare _____

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? _____

RESPIRATORY:

- Cough _____
- Asthma or wheezing _____

GENITAL/ URINARY:

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

MUSCULOSKELETAL:

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

HEMATOLOGICAL:

- Anemia or low blood sugar _____
- Excessive bruising or bleeding _____
- Recurrent infections or infections that will not go away _____

ENDOCRINE:

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

If you are female, please read the following carefully:

Are you pregnant or planning to become pregnant? (circle one) YES NO

Please be advised that as part of your consultation/evaluation and treatment you are responsible to avoid an accidental pregnancy. Various medications, X-rays, CAT/MRI scans are contraindicated for pregnant women and may be very dangerous.

I n complete understanding of the above and certifying that all information is true to the best of your knowledge, please sign below.

Patient Signature

Print Name

Thank you for taking time to complete this form. All of the information is important to us in caring for you.

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 _____
- Does not travel at all _____

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:

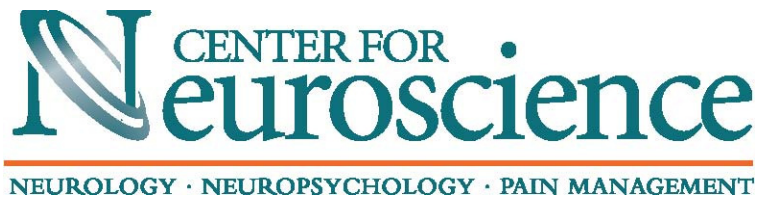
- Takes care of all shopping needs independently _____
- Shops independently for small purchases _____
- Needs to be accompanied on any shopping trip _____
- Completely unable to shop _____
- Does not apply _____

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 _____



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 :

PRIMARY CARE _____

INTERNIST _____

OTHER _____

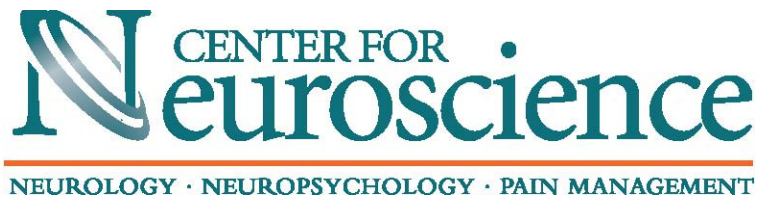
Patient's Signature: _____

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: _____

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 rejected. The undersigned agrees to pay all costs of collection, including a reasonable attorney's fee, and agrees 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 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 \$25.00 for each hour scheduled.

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

M. Farhan 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

Release of Liability

I agree to disclose in writing my physical and medical conditions and limitations and sensitivities; and hereby release and hold the Center for NeuroScience, its agents and employees harmless from any liability, claims, conditions, limitations or sensitivities. I expressly agree that utilization of the facilities and equipment shall be undertaken at my own risk, and I represent that I am physically and medically able to participate in the physical therapy conditioning program.

- Herniated Discs
- Spondylolisthesis
- Joint Replacement
- Dislocating Joint
- Joint Pain
- Cardiac Surgery or rhythm disturbances
- Pulmonary/Breathing problems
- Recent Fracture
- Pregnancy
- Nerve Pain

Other physical or medical condition or limitations: _____

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 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

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

Center for Neuroscience

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

FOR OFFICE USE ONLY

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.

CENTER FOR Neuroscience

NEUROLOGY · NEUROPSYCHOLOGY · PAIN MANAGEMENT

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:** _____

16244 S. Military Trail, Suite 150, Delray Beach, Fl., 33484
10189 W. Sunrise Blvd. Plantation, Fl., 33322
1633 North Hiatus Road, Pembroke, Fl., 33026
561-638-8872 FAX 561-638-8874