GAINESVILLE OPEN MRI

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

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

1. The 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services.
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 amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction up to $500.00.

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. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of the 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 (15) and (16), Florida Statutes or Section 627.736 (5)(b)6, Florida Statutes.

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 own hand):

_____	_____	_____
Name (Print or Type)	Signature	Date

Any person knowingly 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)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.763(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of this claim.