RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

LETTER of PROTECTION

Letter of Protecton for Patient/Client: _____

Thank you for referring your client to Synapse Neurology, Dr. Raam Sambandam.

PROTECTION OF OUTSTNDING CHARGES: This letter of protection serves to provide Synapse Neurology with assurance that we will be paid any out of settlement proceeds the portion of our bills that is not paid by the patient's personal injury protection benefits (if any) and/or health insurance coverage (if any) excluding any Medicaid or Medicaid affiliate insurnaces.

AMOUNT PROTECTED: As a health care provider we will furnish your office with periodic updates of outstanding charges and medical records. We as a health care provider agree to bill any personal injury protection benefits and health insurance (if any) excluding Medicaid or Medicaid affiliate insurances for any patient over the age of 18.

APPROVAL REQUIRED: This letter of protection becomes effective when you and the client approve it is writing in the space provided below and return it to our office.

This letter is not intended to infer that you, in any way, have a financial interest in the outcome of your client's case, This letter is to ensure that Synapse Neurology is taking a risk by treating your client who otherwise has no means to pay and we simply expect to get paid for the services, care and treatment that we provide to your client.

In the event that our patient, your client does not recover his/her personal injury action please understand that the remaining balance of our medical bill will become the sole responsibility of your client/our patient and that we are entitled to collect the balance due and pending.

Should you need anything further, please do not hesitate to contact us at 352-404-7712.

Sincerely,

Synapse Neurology

Client Patient:_____ Attorney: _____

Date_____ Date_____

1925 Don Wickham Drive, Clermont, Florida 34711
Phone: 352-404-7712
Fax : 352-404-7713
INFO@SYNAPSENEUROLOGY.COM

Only complete if involved in MVA/Slip & Fall:

Date of accident: ____/____/____ Location of MVA:_____
Please describe the accident in your own words: _____

_____
_____
_____
_____
_____

Were you:
DRIVER / FRONT PASSENGER / REAR PASSENGER / PEDESTRIAN / BICYCLIST

Does your vehicle have an airbag: YES NO Did your airbag deploy: YES NO
Were you wearing: LAP SEATBELT SHOULDER SEATBELT HELMET
Did your car or bicycle impact another vehicle? YES NO
Was impact from: FRONT REAR LEFT SIDE RIGHT SIDE
What was the aprox speed at the time of impact: _____ MPH

At the time impact were you: LOOKING STRIGHT AHEAD LOOKING UP
LOOKING DOWN LOOKING TO THE LEFT LOOKING TO THE LEFT

Immediately after the accident, where did you experience pain? Be specific:

_____
_____

Did you go to the hospital: YES NO IF yes, how did you get there: _____
Were you admitted to the hospital: YES NO How long was your stay: _____

Have you received medical &/or therapeutic treatment since your injury? YES NO
If yes, what type of care have you received (i.e. emergency, chiropractic, naturopathic, massage, etc)? _____

Have you retained an attorney? YES NO Name of attorney: _____
Did you have any pain similar to this prior to your MVA?

_____
_____

Is there anything else you would like me to know about your MVA?

_____
_____

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

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ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile, health or casualty insurance which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to "Synapse Neurology", as, Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due to owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. I further agree to pay any applicable deductible or co-payment not covered by my insurance. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize my insurance company to release any information that is pertinent to my case to Assignee. I hereby request a copy of the PIP log, declaration sheet and copy of the insurance policy, which reflects the policy limits available at the time of the accident, to be provided to the Assignee. I further authorize Assignee to request and receive a copy of my PIP log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of the Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

Patient _____ **Date**_____

Guardian _____

[illegible]ROLOGICAL CARE, PA. [illegible] CLERMONT, FL 34711
[illegible] FAX INFO@SYNAPSENEUROLOGY.COM

OFFICE OF INSURANCE REGULATION
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 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 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)6, 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)(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.

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