LAW OFFICES OF
MICHAEL B. BREHNE, P.A.
PERSONAL INJURY • INSURANCE DISPUTES • FAMILY LAW • CRIMINAL LAW

PERSONAL INJURY CHECKLIST

Check if Needed	Item to be completed	Initials / Date Completed
	Initial letter to the client	
	Follow-up appointment (30, 45, and 60 days)	
	Referral letters (associating attorney & client)	
	Thank you note (handwritten)	
	Request medical records _____ Hospital _____ ER Physician _____ Radiologist _____ Pathologist _____ MRI _____ Doctor(s) _____ Ambulance _____ Other	
	Letter to clients ☐ Auto ☐ Health ☐ Comp Insurance _____ Include PIP app., wage verification Set aside $_____ for lost wages	
	Put Medicare / Medicaid on Notice	
	Letter to Defendant(s)	
	Letter to Defendant(s) Insurance	
	Accident Report (by mail or by hand)	
	Property damage photos (By _____)	
	Personal Injury photos (By _____)	
	Title Info from DHSMV (☐ Client's ☐ Defendant's)	
	Witness statements (By _____) _____ by _____ _____ by _____	
	Defendant's driving record	
	Plaintiff(s)' – Defendant(s)' criminal history	
	State attorney's file if DUI	
	Accident reconstruction (By _____)	
	IRS Form 4506 (tax records)	
	Notes:	
	Is Defendant an agency or instrumentality of government origin? YES NO Statute of Limitation: _____	

PHONE: (407) 645-2195
FAX: (407) 645-2317
230 N WESTMONTE DRIVE, SUITE 1000
ALTAMONTE SPRINGS, FL 32714
MBREHNE@BREHNELAW.COM
WWW.BREHNELAW.COM
WWW.911BIKERLAW.COM

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AUTHORITY TO REPRESENT

I, the undersigned client, to hereby retain THE LAW OFFICES OF MICHAEL B. BREHNE, P.A., as my attorneys to represent me in my claim for damage(s) against _____ or any other person, firm, or corporation liable there for, resulting from an accident that occurred on _____. I acknowledge that THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. may advance the costs of bringing this claim or lawsuit, but that these costs will be deducted from my share of the recovery or paid in advance of transferring the file to another attorney. I agree that THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. will be paid as follows:

a. Before the filing of an answer or the demand form appointment of arbitrators or, if no answer is filed, or no demand for appointment or arbitrators is made, the expiration of the time period provided for such action:
   1. 33 1/3% of any recovery up to $1 million; plus
   2. 30% of any portion of the recovery between $1 million and $2 million; plus
   3. 20% of any portion of the recovery exceeding $2 million.

b. After the filing of an answer, or the demand for appointment of arbitrators, or if no answer is filed, or no demand for appointment of arbitrators is made, the expiration of the time period provided for such action, through the entry of judgment:
   1. 40% of any recovery up to $1 million; plus
   2. 30% of any portion of the recovery between $1 million and $2 million; plus
   3. 20% of any portion of the recovery exceeding $2 million.

c. If all defendants admit liability at the time of filing their answers and request a trial only of damages:
   1. 33 1/3% of any recovery up to $1 million; plus
   2. 20% of any portion of the recovery between $1 million and $2 million; plus
   3. 15% of any portion of the recovery exceeding $2 million.

d. An additional 5% of any recovery after notice of appeal is filed or post-judgment relief or action is required for recovery on the judgment.

If any suit brought on my behalf entitles me to have the defendant pay my attorney's fees, then I agree to pay THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. those fees as determined by the court or the above contingency, whichever is greater. I further understand that the fees as set by the court may well exceed the above contingency figures depending on the amount of time my attorney expends in the prosecution of my case, the difficulty, novelty, or complexity of my case, and the amount ultimately paid or rewarded.

THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. will only charge a fee if there is a recovery. Any protected medical bills or hospital/worker's compensation liens will be deducted from the client's share of the recovery. The client shall inform THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. of any change in address, and any failure to do so will relieve this office of any duty to prosecute this claim. THE LAW OFFICES OF MICHAEL B. BREHNE, P.A. is further relieved of any responsibility to prosecute this claim if the client provides false or misleading information or intentionally omits a material fact related to representation.

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The undersigned client has, before signing this contract, received and read the statement of client's rights and understands each of the rights set forth therein. The undersigned client has signed the statement and received a signed copy to refer to while being represented by the undersigned attorney(s). This contract may be cancelled by written notification to the attorney at any time within 3 business days of the date the contract was signed, as shown below, and if cancelled the client shall not be obligated to pay any fees to the attorney for the work performed during that time. If the attorney has advanced funds to others in representation of the client, the client agrees the attorney is entitled to be reimbursed for such amounts as the attorney has reasonably advanced on behalf of the client and that payment of said costs is required before client may receive a copy of their file.

Client Signature	Date
Client Signature	Date
Attorney Signature	Date

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STATEMENT OF CLIENTS' RIGHTS

Before you, the perspective client, arrange a contingency agreement with a lawyer, you should understand this Statement of your Rights as a client. This Statement is not a part of the actual contract between you and your lawyer, but as a prospective client, you should be aware of these rights.

1. There is no legal requirement that a lawyer charge a client a set fee of a percentage of money recovered in a case. You, the client, have the right to talk to your lawyer about the proposed fee and to bargain about the rate or percentage as in any other contract. If you do not reach an agreement with one lawyer, you may talk with other lawyers.

2. Any contingency fee contract must be in writing. You have three (3) business days to reconsider the contract. You may cancel the contract without any reason if you notify your lawyer in writing within three (3) business days of signing the contract. If you withdraw from the contract within the first three (3) business days, you do not owe the lawyer a fee although you may be responsible for the lawyer's actual costs during that time. If your lawyer begins to represent you, your lawyer may not withdraw from the case without giving you notice, delivering necessary papers to you, and allowing you time to hire another lawyer. Often your lawyer must obtain court approval before withdrawing from a case. If you discharge your lawyer without good cause after the three (3) day period, you have to pay a fee for work the lawyer has done.

3. Before hiring a lawyer, you, the client, have the right to know about the lawyer's education, training and experience. If you ask, the lawyer should tell you specifically about their experience dealing with cases similar to yours. If you ask, the lawyer should provide information about special training or knowledge and provide this to you in writing if you request it.

4. Before signing a contingency fee contract with you, a lawyer must advise you whether he or she intends to handle your case alone or whether other lawyers will be helping with the case. If your lawyer intends to refer the case to other lawyers, he should tell you what kind of fee sharing agreement will be made with the other lawyers. If lawyers from different law firms represent you, at least one lawyer from each firm must sign the contingency fee contract.

5. If your lawyer intends to refer your case to another lawyer or counsel with other lawyers, your lawyer should tell you about that at the beginning. If your lawyer takes the case and later decides to refer your case to another lawyer or associate with other lawyers, you should sign a new contract, which includes the new lawyers. You, the client, also have the right to consult with each lawyer working on your case and each lawyer is legally responsible to represent your interests and is legally responsible for the acts of the other lawyers involved in the case.

6. You, the client, have the right to know in advance how you will need to pay the expenses and legal fees at the end of the case. If you pay a deposit in advance for costs, you may ask reasonable questions about how the money will be or has been spent and how much of it remains unspent. Your lawyer should give you a reasonable estimate about future necessary costs. If your lawyer agrees to advance of lend you money to prepare or research the case, you have the right to decide, after consulting with your lawyer, how much money is to be spent to prepare a case. If you pay the expense, you have the right to decide how much to spend. Your lawyer should inform you whether the fee will be based on the gross amount recovered or the amount recovered minus costs.

7. You, the client, have the right to be told by your lawyer about possible adverse consequences if you lose the case. The adverse consequences might include money that you might have to pay your lawyer for costs, and liability you might have for attorney's fees to the other side.

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8. You, the client, have the right to receive and approve a closing statement at the end of the case before you pay any money. The statement must list all of the financial details of the entire case, including the amount recovered, all expenses.

9. You, the client, have the right to ask your lawyer at reasonable intervals how the case is progressing and to have these questions answered to the best of your lawyer's ability.

10. You, the client, have the right to make the final decision regarding settlement of a case. Your lawyer must notify you of all offers of settlement before and after the trial. Offers during the trial must be immediately communicated and you should consult with your lawyer regarding whether to accept a settlement.

11. If at any time, you, the client, believe that your lawyer has charged an excessive or illegal fee, you, the client, have to report the matter to The Florida Bar, the agency that oversees the practice and behavior of all lawyers in Florida. For information on how to reach The Florida Bar, call 1-800-342-8060, or contact the local bar association. Any disagreement between you and your lawyer about a fee can be taken to court and you may wish to hire another lawyer to help you resolve this disagreement. Usually disputed fees must be handled in a separate lawsuit.

Client Signature	Date
Client Signature	Date
Attorney Signature	Date

Please answer the following questions as best as you can.

PERSONAL INFORMATION

1. CLIENT / PATIENT INFORMATION

Guardian of injured person, if applicable: _____

Injured person(s): _____ Date of Birth: _____

Social Security #: _____ Drivers Lic #: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

How long have you

Email: _____

Place of Birth: _____ lived in Florida: _____

Marital Status: _____ If married, spouse's name: _____

Dependent Children (names/ages): _____

Criminal Convictions: YES NO

If YES, please list: _____

Who referred you to this firm? _____ Is this person an attorney? YES NO

2. EMPLOYMENT INFORMATION

(Please include all employment / employers during the past 12 months prior to the accident).

Occupation: _____ Hire Date: _____

Employer: _____

Address: _____

Supervisor's Name: _____ Salary: _____

Did you miss any work because of this accident? YES NO

Dates absent from work: _____

Were you injured **on the job?** YES NO

Occupation: _____ Hire Date: _____

Employer: _____

Address: _____

Supervisor's Name: _____ Salary: _____

Did you miss any work because of this accident? YES NO

Dates absent from work: _____

Were you injured **on the job?** YES NO

3. **ACCIDENT INFORMATION**

Date of accident: _____ Time of accident: _____

Location of accident: _____

City: _____ State: _____ County: _____

How did the accident happen? _____

_____

_____

Which agency investigated the accident? _____

Accident or Incident Report #: _____

4. **PROPERTY DAMAGE INFORMATION (AUTO ACCIDENT ONLY)**

Vehicle description: _____ Year: _____ Make: _____ Model: _____

Area(s) of damage: _____

Written estimates of damages? YES NO If YES, please furnish a copy.

YES, how much? $ _____

Did you discuss the property damage(s) with the Defendant(s)' adjuster? YES NO

Did you discuss the property damage(s) with your adjuster? YES NO

5. **INJURIES / TREATMENT INFORMATION**

What injuries were sustained? _____

_____

_____

Ambulance YES NO If YES, name: _____

Hospital YES NO If YES, name: _____

Doctors: _____ _____

_____ _____

_____ _____

_____ _____

Did the Physician place you on disability from work? YES NO

If YES, for what period? _____

6. **INSURANCE INFORMATION – DEFENDANT (person/entity causing this accident)**

Defendant #1 Name: _____

Address: _____

Auto-Liability Insurance Carrier Name: _____

Carrier Address: _____

Phone #: _____ Policy #: _____

Claim #: _____

Adjuster: _____ Adjuster Phone: _____

Did you give a statement to the adjuster? YES NO

Defendant #2 Name: _____

Address: _____

Auto-Liability Insurance Carrier Name: _____

Carrier Address: _____

Phone #: _____ Policy #: _____

Claim #: _____

Adjuster: _____ Adjuster Phone: _____

Did you give a statement to the adjuster? YES NO

7. **INSURANCE INFORMATION – CLIENT**

a. **Auto Insurance**

Auto Insurance Carrier Name: _____

Address: _____

Phone #: _____ Policy #: _____

Claim #: _____

Adjuster: _____ Adjuster Phone: _____

Did you give a statement to the adjuster? YES NO

b. Health Insurance

Health Insurance Carrier Name: _____

Address: _____

Phone #: _____ Policy #: _____

Claim #: _____

Adjuster: _____ Adjuster Phone: _____

Did you give a statement to the adjuster? YES NO

Are you eligible for Medicare? YES NO If YES, I.D. #: _____

Are you eligible for Medicaid? YES NO If YES, I.D. #: _____

8. VEHICLES OWNED

Please provide information about ALL vehicles owned by you or by a relative living with you

YEAR	MAKE	MODEL	OWNER	Owners Relationship to YOU

9. PRIOR ACCIDENTS / INJURIES

Have you suffered prior injury to the same part of your body? YES NO

If YES, please list the doctor(s) that treated you?

Doctors: _____ _____

_____ _____

_____ _____

Have you been involved in prior **accidents of ANY kind?** YES NO

If YES, Please complete the following:

Date of Accident: _____ Type of Accident: _____

Primary treating physicians: _____

_____

_____

_____

Were you assessed a permanent injury impairment rating? YES NO

Date of Accident: _____ Type of Accident: _____

Primary treating physicians: _____

_____

_____

_____

Were you assessed a permanent injury impairment rating? YES NO

Date of Accident: _____ Type of Accident: _____

Primary treating physicians: _____

_____

_____

_____

Were you assessed a permanent injury impairment rating? YES NO

LAW OFFICES OF
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PIA) UNDER HIPAA

TO: _____
_____
_____
_____
Attn: Medical Records

RE: Patient Name: _____
Date of Birth: _____
Social Security #: XXX-XX-_____
Date of Accident: _____

I hereby authorize the disclosure of my protected health information to The Law Offices of Michael B. Brehne, P.A. The type and amount of information to be disclosed is as follows: (dates included where appropriate)

_____ Any and all Physician Reports/Records/History
_____ Progress Record/Office Notes
_____ Physical Examinations
_____ Diagnostic Reports
_____ Admission Summary
_____ Emergency Room Records
_____ Operative Reports
_____ Discharge Summary
_____ Itemized Statement for Services Rendered
_____ Prescription List
_____ Other _____

REQUIRED DISCLOSURES – 45 CFR 164.508

The protected health information is to be used for the purpose of representation in a personal injury action.

I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the provider or hospital named herein. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon the conclusion of my legal claim.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other healthcare provider, and that this release has not been coerced by a health care entity or any of its business associates.

I understand that one the information is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

_____ _____
Claimant / Patient Date

_____
Signature of Witness

PHONE: (407) 645-2195
FAX: (407) 645-2517
250 N WESTMONTE DRIVE, SUITE 1000
ALTAMONTE SPRINGS, FL 32714
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1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☐ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☐ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____

4. **Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:**

1. Name: _____

   Address: _____

   _____

2. Name: _____

   Address: _____

   _____

3. Name: _____

   Address: _____

   _____

5. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

_____ _____ _____

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to:**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MSPRC – NGHP
PO BOX 138832
Oklahoma City, OK 73113
Fax: (405)869-3309

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers" compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
( ) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: _____
Relationship to the Medicare Beneficiary: _____
Firm or Company Name: _____
Address: _____
_____
_____
Telephone: _____

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit www.msprc.info for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers'

compensation claim: _____

Beneficiary Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

Authorization for the Use and Disclosure of Protected Health Information

Federal law states that we cannot share an individual's health information without the individual's permission, except in certain situations. By signing this form, you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share this information any more, you can revoke this authorization at any time in writing or sign the REVOCATION SECTION on the back of this form and return it to Xerox Recovery Services. This form must be completed and signed by the Medicaid recipient or by an individual who has the authority to act on the Medicaid recipient's behalf (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

PLEASE COMPLETE THE FOLLOWING SECTIONS

1. **Personal Information:**

   Medicaid Recipient's Name_____ Date of Birth_____

   Medicaid ID Number_____ Social Security Number_____

2. **I give permission to the Agency for Health Care Administration (AHCA) and its contract representatives to share the health information listed below with the following:**

   Name of the Law Firm or Law Office_____
   Name of the Insurance Company_____
   Other_____

3. **Indicate the purpose for which the disclosure is to be made:**

   ____To substantiate Medicaid's lien relating to a lawsuit
   ____To substantiate Medicaid's claim against the estate or against a trust account or annuity
   ____Other _____

4. **Indicate the information that you want to be disclosed, related to the following (check one):**

   ____The Medicaid lien *relating to the injury or negligence* charges, for the period beginning with the date of incident.
   ____Medicaid's claim against the *estate.*
   ____The amount that is due Medicaid from the *trust account, [Please send a copy of the trust agreement].*
   ____The amount that is due Medicaid from the *annuity account, [Please send a copy of the annuity agreement].*
   ____Other, *[Please be specific].* _____

5. **Enter the specific date that you want this authorization to expire: (i.e., one year from date of release)**_____
   (If you do not enter a date, this authorization will expire in five years.)

I understand that the information described above may be redisclosed by the person or group that I hereby give AHCA and its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release AHCA, its workforce members, and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect or request copies of any information disclosed by this authorization if AHCA or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying AHCA through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

6. Recipient Signature_____ Print Name_____ Date_____
   OR
   Name of Legal Representative (Print)_____ Relationship_____

   Signature of Legal Representative *_____ Date_____

* If you are not the individual, but represent the individual, please attach a copy of the legal document that verifies that you are a representative (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

Getting Help to Pay Your Bill

This information is for anyone who receives services from Florida Hospital or an affiliated health care provider. As a faith-based hospital, we provide medical care to all patients, including those who have difficulty paying for services due to limited income. You can ask for help with your bill at any time during your hospital stay or billing process.

FLORIDA HOSPITAL

PO Box 538815
Orlando, FL 32853-9902
Customer Service department
407-303-0500
Fax 407-200-4977
Website: www.floridahospital.com

Qualifying for Help

If you receive emergency or medically necessary services and do not have medical coverage from a commercial insurer or governmental program, you may qualify for financial assistance. The amount of assistance depends on your annual income and family size. If your annual income is equal to or less than 200% of the current Federal Poverty Guidelines you will not have to pay your bill.

Federal Poverty Guidelines	
1	$23,540
2	$31,860

For each additional person, add $8,320

If your income does not meet the guidelines to have your entire bill paid, you may still qualify for help paying part of your bill. You may also qualify based on other factors on your application.

Applying for Help

You can apply for help with your bill in person, by mail, over the phone by calling our Customer Service department at 407-303-0500, or on our website: www.floridahospital.com. You can also pick up an application at various locations throughout the hospital.

Emergency and Medically-Necessary Care

If you qualify for help with your bill, you will not be billed more for emergency or medically-necessary care than people who have insurance coverage are billed. We compare the amount paid by insured patients and their insurance companies to determine how much you owe. You can view our charity policy at www.floridahospital.com.

Supporting Documents

If you want to take part in our financial assistance program, you will be responsible for providing information and paperwork in a timely way. You will need to share all of the information about your health benefits, income, assets, and anything else that will help us determine whether you qualify for assistance. Paperwork might include bank statements, income tax forms and check stubs.

Collection Activities

Bills that are not paid 100 days after the first billing date may be reported to a collection agency. Bills that are not paid 120 days after the first billing date may be reported on your or your guarantor's credit history. You or the guarantor can apply for help with your bill at any time during the collection process by completing an application.

FLORIDA HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

(All fields must be completed unless noted otherwise)

FIN: _____ MRN: _____

Patient Last Name, First	Date of Birth	Social Security Number	*Number of People in Household	Last 12 Months Annual Household Income
				$

If Minor, Guarantor's Last Name, First	Date of Birth	Social Security Number	Guarantor's Source of Income

Vehicles in Household including Cars/Boats/RV's (Year/Make/Model)	Checking/Savings Account Balance	Properties Owned and Values	CD/Retirement/ Investment Account Balances	Other Assets
(Optional)	(Optional)	(Optional)	(Optional)	(Optional)

Patient Street Address	Home Phone Number	If Income is $0, please check one:	
			Lives with Relative(s)
City, State, Zip Code	Alternate Phone Number		Lives with Friend(s)
			Retired
Number of children under age 21 in the home: _____			Unemployed
			Disabled
			Homeless

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will re-evaluate my financial status and take whatever action becomes appropriate. Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083. To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.

For assistance with this application, please call (407) 303-0500.

_____ _____

Signature of Applicant /Guarantor Date Completed

* When calculating the number of people in the household, only the following people are counted: 1) Blood relatives living in the home, 2) Relatives by marriage living in the home, and 3) Relatives by legal adoption living in the home.

For Office Use Only				
Reason for Service	GAI	DOS	Family Size	Total Charges
☐ 1.0x $	☐ 1.5x $	☐ 2.0x $	☐ 25% Rule $	
Recommendation for account disposition				
Finance Committee Disposition				
Manager _____ Date _____		Director _____ Date _____		

CONFLICT WAIVER

It has come to the attention of this office that conflict of interest has arisen regarding our continued representation of your claims. Unfortunately, the at-fault driver's limits were $_____, per person, $_____ total that could be disbursed for all _____ Plaintiffs' injuries. This means that the each of you, _____ are pursuing the same claimed funds.

Rule 4-1.7 of the Florida Rules of Professional Conduct, the rules designating the ethical obligations of attorneys of Florida states:

A lawyer shall not represent a client if the representation of that client will be directly adverse to the interests of another client, unless:

1. the lawyer reasonably believes the representation will not adversely affect the lawyer's responsibilities to and relationship with the other client; and

2. each client consents after consultation.

Thus, it is possible to represent all three of you, as your claims are now competing for the same limited funds by the defendant and make a claim under your underinsured/uninsured motorist coverage (if any) as long as you are advised and agree and consent for our firm to continue to represent all parties.

If you agree to allow us to continue to represent, please execute below. Please feel free to consult another attorney before deciding to sign this document.

_____ _____
Date

_____ _____
Date

_____ _____
Date

CO-COUNSEL ADDENDUM TO CONTRACT FOR LEGAL SERVICES
(Pursuant to Rule 4-1.5 of the Rules Regulating the Florida Bar)

RE: _____

D/I: _____

The undersigned acknowledge and agree that each attorney or law firm sharing in a fee shall be legally liable to the claimant for any professional malpractice of any other attorney or law firm sharing in the fee to the same extent as if they were partners. No attorney shall share in any fee unless the attorney shall be available to the claimant for consultation concerning the matter. No attorney or any other person shall receive any fee merely for referring a claimant to another attorney for representation. The terms for sharing of any fee shall be disclosed to and approved by the client in a written document signed by the client and all attorneys or law firms sharing in the fee. The court shall inquire into the division of fees among attorneys and shall have the power to modify the division of fees between attorneys.

It is agreed and understood that _____ will be acting as co-counsel, and will be receiving 25% of the attorney fees from this matter, and will be assuming secondary responsibility for the legal services on behalf of the Client. However, Law Offices of Michael B. Brehne, PA, will be primarily responsible for the legal services on behalf of the Client, including evaluation, investigation and handling of the client's claim, and will receive 75% of the attorney fees from this matter. **This division of attorney fees will not increase the amount of fees incurred in this matter.**

This Addendum shall be made a part of and incorporated into the "AUTHORITY TO REPRESENT", as if specifically set forth therein, and co-counsel otherwise agrees to be bound by the terms and conditions therein.

Dated in _____ County, this _____ day of _____, 20___.

_____
CLIENT:

_____
CLIENT:

_____
LAW OFFICES OF MICHAEL B BREHNE, PA

_____
CO-COUNSEL

FIRM NAME:
ADDRESS: _____

_____
TELEPHONE NUMBER: _____
FEDERAL TAX ID NUMBER: _____

AUTHORIZATION TO ENDORSE AND DEPOSIT SETTLEMENT INSTRUMENT

Michael B. Brehne of The Law Offices of Michael B. Brehne, P.A. is hereby authorized and directed to endorse my signature on the settlement instrument and to deposit same into his trust/escrow account. I understand that no money will be distributed to anyone without written approval from client.

DATED this _____ day of _____, 20___.

_____

STATE OF FLORIDA
COUNTY OF_____

Sworn to and subscribed before me this ____ day of _____, 20___ by

_____, who is personally known or who produced as I.D. the

following:_____.

_____
NOTARY PUBLIC

My Commission Expires:

PHONE: (407) 645-2195
FAX: (407) 645-2317
230 N WESTMONTE DRIVE, SUITE 1000
ALTAMONTE SPRINGS, FL 32714
MBREHNE@BREHNELAW.COM
WWW.BREHNELAW.COM
WWW.911BIKERLAW.COM