



25-000165355

VIVAX-RAY MEDICAL DIAGNOSTIC CENTER,
INC. A/A/O JOAQUIN MIRABAL

PLAINTIFF(S)

VS.

RESPONSIVE AUTO INSURANCE COMPANY

DEFENDANT(S)

SUMMONS, COMPLAINT

CASE #: 2025-104020-SP-21
COURT: COUNTY COURT
COUNTY: MIAMI-DADE
DFS-SOP #: 25-000165355

NOTICE OF SERVICE OF PROCESS

NOTICE IS HEREBY GIVEN of acceptance of Service of Process by the of the State of Florida. Said process was received in my office by ELECTRONIC DELIVERY on Friday, June 27, 2025 and a copy was forwarded by ELECTRONIC DELIVERY on Monday, June 30, 2025 to the designated agent for the named entity as shown below.

RESPONSIVE AUTO INSURANCE COMPANY (THE)
JOHN D MACHUL
SUITE 1000 8151 PETERS ROAD
PLANTATION, FL 33324

***Our office will only serve the initial process (Summons and Complaint) or Subpoena and is not responsible for transmittal of any subsequent filings, pleadings, or documents unless otherwise ordered by the Court pursuant to Florida Rules of Civil Procedure, Rule 1.080.**

GREGORY GUDIN
LANDAU & ASSOCIATES, P.A
1619 NW 136TH AVE SUITE 2C
SUNRISE, FL 33323

KS1

VIVAX-RAY MEDICAL DIAGNOSTIC
CENTER, INC.
a/a/o Joaquin Mirabal

IN THE COUNTY COURT IN AND
FOR MIAMI-DADE COUNTY,
FLORIDA

Plaintiff,

CASE NO.: 2025-104020-SP-21

vs.

RESPONSIVE AUTO INSURANCE
COMPANY

Defendant.

_____/

THE STATE OF FLORIDA:

TO: RESPONSIVE AUTO INSURANCE COMPANY

c/o Florida Chief Financial Officer as Registered Agent
Service of Process Section
Post Office Box 6200
Tallahassee, Florida 32314-6200

TO EACH SHERIFF OF THE STATE: You are commanded to serve this
Summons and a copy of the Complaint, in this lawsuit on the above-named defendant(s).

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint/petition with the Clerk of this Court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the Court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the Court. There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may call an attorney referral service or a legal aid office (listed in the phone book).


If you choose to file a written response yourself, at the same time you file your written response to the court, you must also mail or take a copy of your written response to the "Plaintiff/Plaintiff's Attorney" named below.

CASE NUMBER: 2025-104020-SP-21

DATED ON 6/24/2025, 2025,

CLERK OF COURT and COMPTROLLER
for MIAMI-DADE COUNTY CIRCUIT and
COUNTY COURTS
JUAN FERNANDEZ-BARQUIN

(SEAL)

By:  Susana Millo
Deputy Clerk

TODD LANDAU, ESQUIRE

Landau & Associates, P.A.
Attorney for Plaintiff
1619 NW 136th Avenue, Suite 2C
Sunrise, Florida 33323
Telephone: (954) 744-8383
Facsimile: (954) 391-7805
Email: efilings@PIP-LAWYERS.com



Juan Fernandez-Barquin,
Clerk of the Court and Comptroller

*In accordance with the American With Disabilities Act, persons with disabilities needing a special accommodation to participate in this proceeding should contact Court Administration: 73 West Flagler Street, Suite # 242, Miami, Florida 33130 (305) 275-1155, not later than 7 days prior to the proceeding not later than 7 days prior to the proceeding.

IMPORTANTE

Usted ha sido demandado legalmente. Tiene 20 Dias, contados a partir del recibo de esta notificación, para contestar la demanda adjunta, por escrito, y presentarla ante este tribunal. Una llamada telefonica no lo protegera. Si usted desea que el tribunal considere su defensa, debe presentar su respuesta por escrito, incluyendo el numero del case y los nombres de las partes interesadas. Si usted no contesta la demanda a tiempo, pudiese perder el case y podria ser despojado de sus ingresos y propiedades, o privado de sus derechos, sin previo aviso del tribunal. Existen otros requisitos legales. Si lo desea, puede usted consultar a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a una de las oficinas de asistencia legal que aparecen en la guia telefonica.

Si desea responder a la demanda por su cuenta, al mismo tiempo en que presenta su respuesta ante el tribunal, debera usted enviar por correo o entregar una copia de su respuesta a la personal denominada abajo como "Plaintiff/Plaintiff's Attorney" (Demandante o Abogado del Demandante).

IMPORTANT

Des poursuites judiciaires ont ete entreprises contre vous. Vous avez 20 jours consecutifs a partir de la date de l'assignation de cette citation pour déposer une réponse écrite a la plainte ci-jointe aupres de ce tribunal. Un simple coup de telephone est insuffisant pour vous proteger. Vous etes obligé de déposer votre réponse écrite, avec mention du numero de dossier ci-dessus et du nom des parties nommees ici, si vous souhaitez que le tribunal entende votre cause. Si vous ne deposez pas votre réponse écrite dans le relai requis, vous risquez de perdre la cause ainsi que votre salaire, votre argent, et vos biens peuvent etre saisis par la suite, sans aucun preavis ulterieur du tribunal. Il y a d'autres obligations juridiques et vous pouvez requerir les services immediats d'un avocat. Si vous ne connaissez pas d'avocat, vous pourriez telephoner a un service de reference d'avocats ou a un bureau d'assistance juridique (figurant a l'annuaire de telephones).

Si vous choisissez de déposer vous-meme une réponse écrite, il vous faudra également, en meme temps que cette formalite, faire parvenir ou expedier une copie de votre réponse écrite au "Plaintiff/Plaintiff's Attorney" (Plaignant ou a son avoca) nomme ci-dessous.

VIVAX-RAY MEDICAL
DIAGNOSTIC CENTER, INC.
a/a/o Joaquin Mirabal

IN THE COUNTY COURT IN AND
FOR MIAMI-DADE COUNTY,
FLORIDA

Plaintiff,

CASE NO.:

vs.

RESPONSIVE AUTO INSURANCE
COMPANY

Defendant

COMPLAINT

COMES NOW, Plaintiff, VIVAX-RAY MEDICAL DIAGNOSTIC CENTER, INC. a/a/o Joaquin Mirabal (hereinafter "Plaintiff") sues the Defendant, RESPONSIVE AUTO INSURANCE COMPANY (hereinafter "Defendant"), and in support thereof alleges the following:

GENERAL ALLEGATIONS

1. This is an action for Breach of Contract for damages in excess of One Dollar (\$1.00) but does not exceed Ninety Nine Dollars and Ninety Nine cents (\$99.99) exclusive of interest, costs and attorney's fees and is within the jurisdictional limits of this Court.

2. Defendant was and remains a corporation organized and existing under the laws of the State of Florida and is otherwise sui juris.

3. Defendant was and is a corporation authorized to do business, maintains an office and agents in MIAMI-DADE COUNTY and regularly sells automobile insurance policies to the general public in MIAMI-DADE COUNTY. The Defendant and/or its affiliates and/or its subsidiaries which issued the policy of insurance have substantial identities of interest.

4. At all times material hereto, Plaintiff was a corporation duly licensed to perform medical services in the State of Florida.

5. On or about September 4, 2020, Joaquin Mirabal (hereinafter "Claimant") was involved in a motor vehicle accident.

6. As a result of that motor vehicle accident, Plaintiff provided Claimant with medical services and/or treatment.

7. As a direct and proximate result of the injuries sustained by Claimant in the accident, Claimant incurred reasonable expenses for necessary medical and rehabilitative care by the Plaintiff for an Emergency Medical Condition as evidenced by the Claimant's entire medical record. To date, Defendant refuses to pay the full amount due.

8. Defendant issued a policy of insurance to Joaquin Mirabal which provided personal injury protection benefits coverage required by law to comply with Florida Statutes Sections 627.730 thru 627.7405. Plaintiff does not have a copy of the policy to attach; however, Plaintiff believes that the Defendant has a copy of said policy. Upon receipt of a certified copy of the insurance policy, same is hereby attached and incorporated herein by reference.

9. The above described policy was in full force and effect on the date of the accident and provided PIP coverage for Joaquin Mirabal for bodily injuries sustained in said accident.

10. Plaintiff and Claimant have performed the statutorily required conditions precedent to entitle Plaintiff to recover benefits for said necessary medical, rehabilitative and remedial treatment regarding the above-described policy and statutory conditions precedent to instituting this action.

11. Claimant equitably assigned to Plaintiff and/or also executed a written assignment of benefits, assigning to Plaintiff certain benefits payable pursuant to the policy of insurance issued by Defendant.

12 Pursuant to said Assignment, Plaintiff gave notice of the covered losses and Plaintiff made demand for PIP benefits for reasonable, necessary and related medical treatment.

13. Defendant has denied coverage for, withheld or reduced the medical bill(s) that were submitted by Plaintiff for date(s) of service September 11, 2020 and/or misapplied the application of the deductible. Furthermore, Defendant was precluded from applying a deductible at all because the nonexistence of a properly executed deductible election form. A copy of the HCFA bills and/or patient ledger and/or explanation of benefits/review are attached hereto and incorporated by reference. Due to the failure of Defendant to pay these PIP benefits in accordance

with the law, Plaintiff has been required to retain the undersigned law firm to act on their behalf in this suit. Plaintiff has agreed to pay, and the attorneys for Plaintiff have agreed to accept, any court awarded fee.

BREACH OF CONTRACT FOR FAILURE TO PAY AMOUNTS OWED.

14. Plaintiff reavers and realleges paragraphs 1 through 13 of this complaint.

15. Despite prior demand by Plaintiff, Defendant has refused and continues to refuse to issue payment of all sums due Plaintiff, in violation of Section 627.736, Florida Statutes, and in breach of its contract with claimant.

16. Plaintiff has retained the undersigned firms to represent it in this action and has agreed to pay a reasonable fee for said services.

17. Pursuant to Section 627.428, Florida Statutes, Plaintiff is entitled to recover from Defendant reasonable attorney's fees and costs for the necessity of this action.

WHEREFORE, Plaintiff requests:

- a. That this Honorable Court declare that Defendant is overdue in payment of all sums due to Plaintiff;
- b. That Defendant pay all sums due to Plaintiff under Claimant's policy of Insurance with Defendant;
- c. That Defendant pay interest on all overdue amounts and/or late payments made in accordance with Section 627.736(4);
- d. That Defendant pay Plaintiff pre-suit penalty, postage, and interest in accordance with Section 627.736(10), Florida Statutes.
- e. That the Defendant correctly apply the deductible "to 100 percent of the expenses and losses" as described in Fla. Stat. 627.736, if applicable;
- f. That The Defendants pay all sums due to Plaintiff under any medical payment's (med-pay) coverage's in accordance with the Claimant's/policy holder's policy of Insurance with Defendant;

- g. That Defendant pay Plaintiff reasonable attorney's fees and costs pursuant to Sections 627.428, Florida Statutes, and/or 627.736(5), Florida Statutes, for the necessity of this action;
- h. Any other relief this Court deems just and appropriate.

WHEREFORE, Plaintiff demands judgment for personal injury protection benefits together with pre-judgment interest, costs and attorneys' fees pursuant to Florida Statute 627.428 and Florida Statute sections 627.736(5) and (8) and any other relief this Court deems proper and just.

Plaintiff demands trial by jury on all issues triable as of right.

LANDAU & ASSOCIATES, P.A.
1619 NW 136th Avenue, Suite 2C
Sunrise, Florida 33323
Telephone (954) 744-8383
Facsimile (954) 391-7805
Email: efilings@pip-lawyers.com

By: /S/ Todd Landau
TODD LANDAU, ESQ.
Florida Bar No. 0489433

VIVAX-RAY MEDICAL DIAGNOSTIC CENTER, INC
3750 WEST 16 AVE SUITE 204-206-Hialeah, FL 33012

PH: 305-825-1418 FAX: 305-825-1419

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek \$627,428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless the insured has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the **Office Manager**. See 673.3111.

EUIOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. Pursuant to F.S. §92.33 and Rule 69B-220.201 (3)(j) of the Florida Administrative Code the undersigned patient/insured hereby makes demand for any and all written and sworn statements.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insured is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name

JOAQUIN MIRABOL
(Please Print)

Patient's Signature

[Signature]
(If patient is a minor, signature of parent)



The Responsive Auto Insurance Company
 Claims Department
 P.O. Box 17960
 Plantation, FL 33318

RECONSIDERATION (REV 1)

Claim Information

Explanation of Benefits - This is not a Bill

Claim Number: C0000008657
 Claimant Name: Concep, Joaquin
 Date of Loss: 09/04/2020
 Policy Holder / No.: Joaquin Concep / 220-101780401
 State of Jurisdiction: FL
 Coverage Type: Personal Injury Protection

Bill Number: 0000078662
 Date Received: 10/16/2020

VIVAX RAYMED DIAGNOSTICCNTN
 3750 W 16 AVE
 HIALEAH, FL 33012-4661

(PROVIDER COPY)

Provider Information

Name: VIVAX RAYMED DIAGNOSTICCNTN
 Address: 3750 W 16 AVE
 HIALEAH, FL 33012-4661
 Provider Invoice #: MIRABALJ 3789
 Specialty: GP
 TIN: 870789931
 NPI / CMS ID: 1821259169 / 1GME63
 Region: 4
 Zip of Service: 33012-4661

ICD Diagnosis

(A) M54.2 (B) S23.3XXA (C) S33.5XXA (D) M25.511 (E) M25.512

Submitted Charges

Date of Service	Line	POS	Proc. Code	Mod.	Dx Ptr	Units	Amount Charged	Amount Allowed	Explanation Codes
09/11/2020	1	11	72040			1	\$366.48	\$81.10	X3043
	2	11	72070			1	\$336.35	\$85.68	X3253
	3	11	72100			1	\$329.40	\$90.90	X3253
	4	11	73030			1	\$321.93	\$70.80	X3043
	5	11	73030			1	\$321.93	\$70.80	X3043
Sub Totals:							\$1,676.09	\$399.28	
Claimant Responsibility									
Co-Payment:								(\$79.86)	
Totals:							\$1,676.09	\$319.42	

Explanation Code Guide

X3043 The allowed amount for this procedure is based upon 200% of the Participating Level of Medicare Part B fee schedule for the region in which the services were rendered. (Reference: CMS Physician Fee Schedule File)

X3253 The allowed amount for this procedure is based upon 200% of the 2007 Participating Level of Medicare physician fee schedule for the region in which the services were rendered, which is higher than the current fee established for the date of service, pursuant to Florida Statute 627.736(5).

Place of Service (POS) Guide

11 Office

Phone: (954)436-8800

Fax: (866)568-2270

Date: 12/09/2020; Adjuster: Ortiz, Joseph; Phone: 9544368800

CPT five digit codes and/or nomenclature are Copyright © 1995-2019 American Medical Association. All rights reserved.



RESPONSIVE AUTO INSURANCE
PO BOX 17960
PLANTATION FL 33318

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) C0000008657									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MIRABAL, JOAQUIN										3. PATIENT'S BIRTH DATE SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
										8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) FL									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 09/11/20										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 04 20 QUAL 431										15. OTHER DATE QUAL 454 MM DD YY 09 11 20									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN LETICIA J MARTINEZ ARNP										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ZZ261QH0100X										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO S CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M542 B. S233XXA C. S335XXA D. M25511 E. M25512 F. L G. L H. L I. L J. L K. L L. L										22. RESUBMISSION CODE ORIGINAL REF. NO									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										23. PRIOR AUTHORIZATION NUMBER									
09 11 20 09 11 20 11 72040 ABCD 366 48 1										1G ME63009 NPI 1821259169									
09 11 20 09 11 20 11 72070 ABCD 336 35 1										1G ME63009 NPI 1821259169									
09 11 20 09 11 20 11 72100 ABCD 329 40 1										1G ME63009 NPI 1821259169									
09 11 20 09 11 20 11 73030 45 ABCD 321 93 1										1G ME63009 NPI 1821259169									
09 11 20 09 11 20 11 73030 45 ABCD 321 93 1										1G ME63009 NPI 1821259169									
										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 870789931 <input checked="" type="checkbox"/> X										26. PATIENT'S ACCOUNT NO. 3789 MIRABALJ									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 10/14/20 DATE										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
32. SERVICE FACILITY LOCATION INFORMATION VIVAXRAY MED DIAGNOSTIC CNTR 3750 WEST 16 AVE HIALEAH FL 33012-4661										28. TOTAL CHARGE \$ 167609 29. AMOUNT PAID \$ 30. Rsrvd for NUCC Use									
33. BILLING PROVIDER INFO & PH # (305) 8251418 VIVAX-RAYMED DIAGNOSTICCNTR 3750 WEST 16 AVE HIALEAH FL 33012-4661										a. 1821259169 b. 1G ME63009									

Total Charges: \$1,676.09
Insurance Payments: \$355.07

VIVAX-RAY MEDICAL DIAGNOSTIC
CENTER, INC.
a/a/o Joaquin Mirabal

I N THE COUNTY COURT IN AND FOR
MIAMI-DADE COUNTY, FLORIDA

Plaintiff,

CASE NO.:

vs.

RESPONSIVE AUTO INSURANCE
COMPANY

Defendant,

_____/

**PLAINTIFF'S INITIAL DISCOVERY DISCLOSURES PURSUANT TO FLORIDA
RULE OF CIVIL PROCEDURE 1.280**

Plaintiff, by and through the undersigned counsel, makes the following initial disclosures as required by Florida Rule of Civil Procedure 1.280:

INDIVIDUALS WITH DISCOVERABLE INFORMATION

1. Plaintiff's Corporate Representative.
2. Claimant, who was injured in this accident and received services provided by Plaintiff. will have knowledge of the accident, injuries sustained from the accident, and any treatment received.
3. Treating provider(s) will have knowledge of the services Plaintiff provided Claimant and the reasonableness, relatedness, and medical necessity of same.
4. Defendant's litigation adjuster with the most knowledge of subject claim.
5. Defendant's pre-litigation adjuster with the most knowledge of subject claim.
6. Defendant's underwriting representative with most knowledge of subject policy.
7. Any and all adjusters/representatives for Defendant who handled the underlying claim.
8. Any and all chiropractors and/or medical doctors and/or physicians' assistants and/or advanced registered nurse practitioners and/or physical therapists and/or other providers who treated Claimant in the underlying claim will have knowledge of their treatment provided to Claimant.
9. Records custodians for any other providers who treated Claimant in the underlying claim will have knowledge of the authenticity of the records.
10. The named insured(s), including the named insured who signed the underlying application for insurance.
11. Any and all individuals named in Defendant's initial discovery disclosures.

Plaintiff reserves the right to amend its disclosure of individuals with discoverable information and will file a Witness List as required by any trial order issued by the Court.

RELEVANT DOCUMENTS IN SUPPORT OF CLAIM

1. Plaintiff's patient file for Claimant, including but not limited to, ledger reflecting all medical charges, HCFAS/CMS forms/bills, treatment notes, progress notes, examination reports/medical reports, x-ray/MRI reports and corresponding films, intake forms filled out by patient, any and all forms of proofs of mailing the bills and/or records at issue (including but not limited to copies of the envelopes, claim system screenshots, mail logs, fax confirmations, etc.), any notice of initiation of treatment and proof of submission, disclosure and acknowledgement form, etc.
2. Any and all medical records where claimant treated for the accident in question.
3. Any and all documents to be exchanged and/or requested in discovery, including Defendant's entire non-privileged claims file.
4. Copies of the applicable policy and/or declarations page(s) including any amended or renewal declarations pages and the application(s) for insurance.
5. Plaintiff's demand letter(s) to Defendant.
6. Any and all demand response(s) issued by Defendant after receipt of any demand letter(s).
7. Defendant's underwriting guidelines and entire underwriting file including but not limited to proof of premium payments made by the insured, notice(s) of rescission, proof of mailing for notice(s) of rescission, documents related to how the relevant premium(s) were calculated, copies of the endorsed premium refund drafts, etc.
8. Physicians Fee & Coding Guide for year in which services were performed.
9. Any and all documents maintained by and/or available to the agency listed on the underlying application for insurance including but not limited to applications for insurance, declarations pages, proofs of payments/receipt of payments, correspondences with the insured and/or claimant(s), reports and/or searches done prior to and/or in preparation for filling out the application for insurance, etc.
10. Any examinations under oath or sworn statements taken in the underlying claim.

Plaintiff reserves the right to amend its disclosure of individuals with discoverable information and will file an Exhibit List as required by any trial order issued by the Court.

INFORMATION RELATED TO CALCULATION OF DAMAGES

1. Plaintiff previously submitted its Demand Letter(s) Pursuant to Florida Statute Section 627.736(10), which specifies the damages requested therein. Plaintiff incorporates its Demand Letter(s) in this Initial Discovery Disclosure.

INSURANCE POLICY

1. Defendant issued a policy of insurance which provided personal injury protection benefits coverage required by law to comply with Florida Statutes Sections 627.730 thru 627.7405 and inures to the benefit of Claimant. Defendant has a copy of the certified policy of insurance and same is incorporated herein by reference.

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