

Advanced Medical & Rehab of Miami, Inc.

Checklist of Paperwork Provided: Day 1

I have received the following information:

- Welcome
- Mission Statement
- Company Information/Hours of Operation/After Hours Policy
- Rights and Responsibilities
- HIPPA Notification
- Emergency Preparedness
- Grievance/Complaint Procedure
- Supplier Standards Statement
- Financial Responsibility/Assignment of Benefits (AOB)

For Medicare Patients Only:

- Advance Beneficiary Notice of Non-Coverage (ABN)

Patient Name (Print)

Patient/Guardian Signature

Date

Advanced Medical & Rehab of Miami, Inc.

PATIENT APPLICATION FORM

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance. We look forward to serving you.

AUTHORIZATION OF CARE

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Name (Print)

Patient's Signature

Date

Minor's Name (Print)

Guardian's Signature (*Authoring Care for Minor*)

Date

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Advanced Medical and Rehab of Miami, Inc. and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initials)

Patient's Name (Print)

Patient/Guardian Signature

Date

MEDICAL RECORDS RELEASE FORM

In order to provide the best care possible for you, we may share your medical records with your family doctor to let them know the progress you are making with our office.

I, _____ give Advanced Medical and Rehab of Miami, Inc. permission to share any and all medical records with my family doctor.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may revoke this authorization at any time by notifying the office. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient/Guardian Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPPA)

We understand that health information about you and your health is personal and we are committed to protecting your health information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Patient/Guardian Signature

Date

PATIENT INTAKE FORM

GENERAL PATIENT INFORMATION

Patient Name: _____ Age: _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Birth Date: ____ / ____ / ____ Social Security #: _____ - _____ - _____ Marital Status: S M D W
Drivers License Number and State issued: _____ State: _____
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Cell Phone: _____
Spouse's Employer: _____ Occupation: _____

As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders? Yes No If yes, who is your cell phone provider? _____

ACCIDENT INFORMATION

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other Date of Accident: _____
Has the accident been reported? Yes No To Whom? _____ Claim #: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of *Your Health Insurance Company*: _____
Policy # _____ Group # _____
Insured's Name (if different than yours): _____ Insured's SS# ____ / ____ / ____
Relationship to Insured _____ Insured's Birth date ____ / ____ / ____ Employer: _____

Patient Condition

Reason for Visit: _____
When did your symptoms first appear? _____ Is your condition getting worse: Yes No
Rate the severity of your pain on a scale of 1 (least) to 10 (severe) _____
Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps
 Stiffness Swelling Other
How many days in the last week did you feel the pain? _____
Does it interfere with your: Work Family Life Sleep Exercise Recreation
Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down
 Driving

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Patient/Guardian Signature

Date

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt | |
| <input type="checkbox"/> Other _____ | | | | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (Be sure to include dosage and frequency) _____

Please list any surgeries and/or hospitalizations you have had (type & date) _____

Please list any allergies _____

Please list any supplements you are currently taking (vitamins, minerals, herbs) _____

Are you currently on any blood thinners – (aspirin regimen included)? Yes No List Type _____

Contraindications: A few procedures should be avoided if patients have certain conditions. Please answer the following:

Do you have a pacemaker? Yes No Do you suffer from blood clots? Yes No Do you have knee/hip replacement? Yes No

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |

Do you exercise: Yes No How often? 1X 2X 3X 4X 5X per week Other: _____

What activities: Running Jogging Weight Training Cycling Yoga Pilates Swimming Other _____

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Energy Drinks _____ cups/day Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature _____ Date _____

Current Date: _____

Attention: Director of Claims

Insurance Policy #1 (carrier): _____

Insurance Policy #2 (address): _____

Re: Patient Name: _____

Policy No: _____

Insured: _____

Dear Director of Claims:

This letter is to inform you that I was not involved in any auto or work injury for this diagnostic test and/or treatment. By signing below, I am stating that I was not involved in any auto accident or personal injury caused by any third party. I further affirm that the diagnostic test and/or treatment being performed is not the result of a work-related injury or caused by any individual related to my employment.

Sincerely,

Patient/Guardian Signature

**LIFETIME AUTHORIZATION ASSIGNMENT OF BENEFITS
AND INSURANCE RELEASE**

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I hereby authorize Advanced Medical and Rehab of Miami, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered prescriptions or durable medical equipment and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Advanced Medical and Rehab of Miami, Inc. I hereby authorize Advanced Medical and Rehab of Miami, Inc. to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. I further agree that I am responsible for paying my co-pays or balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

Patient Name (Print)

Patient Signature

Date

Staff Member Name (Print)

Staff Member Signature

Date

ASSIGNMENT OF BENEFITS for Medicare Patients Only

I request that payment of authorized Medicare benefits be made to me or on my behalf to Advanced Medical and Rehab of Miami, Inc. for treatment or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services for me to release it to the Center for Medicare/Medicaid Services and its agency. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

Item(s) Provided: _____

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

Patient Name (Print)

Patient Signature

Date

Staff Member Name (Print)

Staff Member Signature

Date

2014 CARDIOVASCULAR EXAM AND SCREENING QUESTIONNAIRE

Patient Name (Print): _____

Date: _____

Age: _____

Gender: M F

Blood Pressure: _____

Pulse: _____

Please check the appropriate response.

YES

NO

- | | | |
|---|-------|-------|
| 1. Are you over the age of 45? | _____ | _____ |
| 2. Do you suffer from headaches? | _____ | _____ |
| 3. Do you have a family history of cardiovascular disease (heart) or strokes? | _____ | _____ |
| 4. Do you have high blood pressure or high cholesterol? | _____ | _____ |
| 5. Do you suffer from dizziness or light-headedness? | _____ | _____ |
| 6. Do you smoke or have you smoked in the past? | _____ | _____ |
| 7. Have you ever experienced tingling or numbness in your arms or legs? | _____ | _____ |
| 8. Do you bruise easily? | _____ | _____ |
| 9. Do you get tired easily or feel fatigued after common physical activity? | _____ | _____ |
| 10. Do you have a stressful lifestyle? | _____ | _____ |
| 11. Do you have pain in your legs after walking? | _____ | _____ |
| 12. Do your legs, ankles, or hands swell during the day? | _____ | _____ |
| 13. Do you take medication for high blood pressure or cholesterol? | _____ | _____ |
| 14. Do you take birth control pills? | _____ | _____ |
| 15. Do you have varicose veins? | _____ | _____ |
| 16. Do you have vision problems (ie. temporary loss of vision, blind spots, floaters)? | _____ | _____ |
| 17. Do you suffer from diabetes? | _____ | _____ |
| 18. Do you have any swollen or stiff joints? | _____ | _____ |

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date

Provider: Chiropractic Associates, Inc.
Physical Therapy Professional Center, Inc.
Advanced Medical and Rehabilitation of Miami, Inc.