

# 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)

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Patient Name (Print)

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Patient/Guardian Signature

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Date

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT  
(CONSENT TO USE PHI)**

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**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Advanced Physical Medicine & Rehab of Miami, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*By my signature below, I give my permission to use and disclose my health information  
as stated in the notice of privacy practices.*

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## 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 Physical Medicine & Rehab of Miami, LLC 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 \_\_\_\_\_ ( Initial )

**Signature of Patient**/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

## 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.

**NAME OF GUARANTOR** (person responsible for guaranteeing payment for all services) \_\_\_\_\_

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 Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Guardian/Spouse's Signature of Authorizing care for minor

\_\_\_\_\_  
Date

I hereby authorize Advanced Physical Medicine & Rehab of Miami, LLC to administer care as deemed necessary to my child, a minor under the age of 18 years old.

## EMERGENCY CONTACT

Name \_\_\_\_\_

Work Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

# Advanced Physical Medicine & Rehab of Miami, LLC

## Patient Intake

### GENERAL INFORMATION

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: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ 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 Number \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

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.

**Signature of Patient**/or Guardian of said Minor \_\_\_\_\_ **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"/> Nausea     |
| <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"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Eczema     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**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"/> Other _____        |
| <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      | _____                                       |

Are you currently pregnant?  Yes  No

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 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 in the office should be avoided if patients have certain conditions.**

Please CHECK if you have any of the following:

- A pacemaker  Suffer from blood clots  Knee/ hip replacement  Local or systemic infection  Egg allergy
- Corticosteroid or Local Anesthetic Allergy  Additional allergies (please list) \_\_\_\_\_

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

- Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Other \_\_\_\_\_
- Cancer \_\_\_\_\_  Arthritis \_\_\_\_\_  Other \_\_\_\_\_

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

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

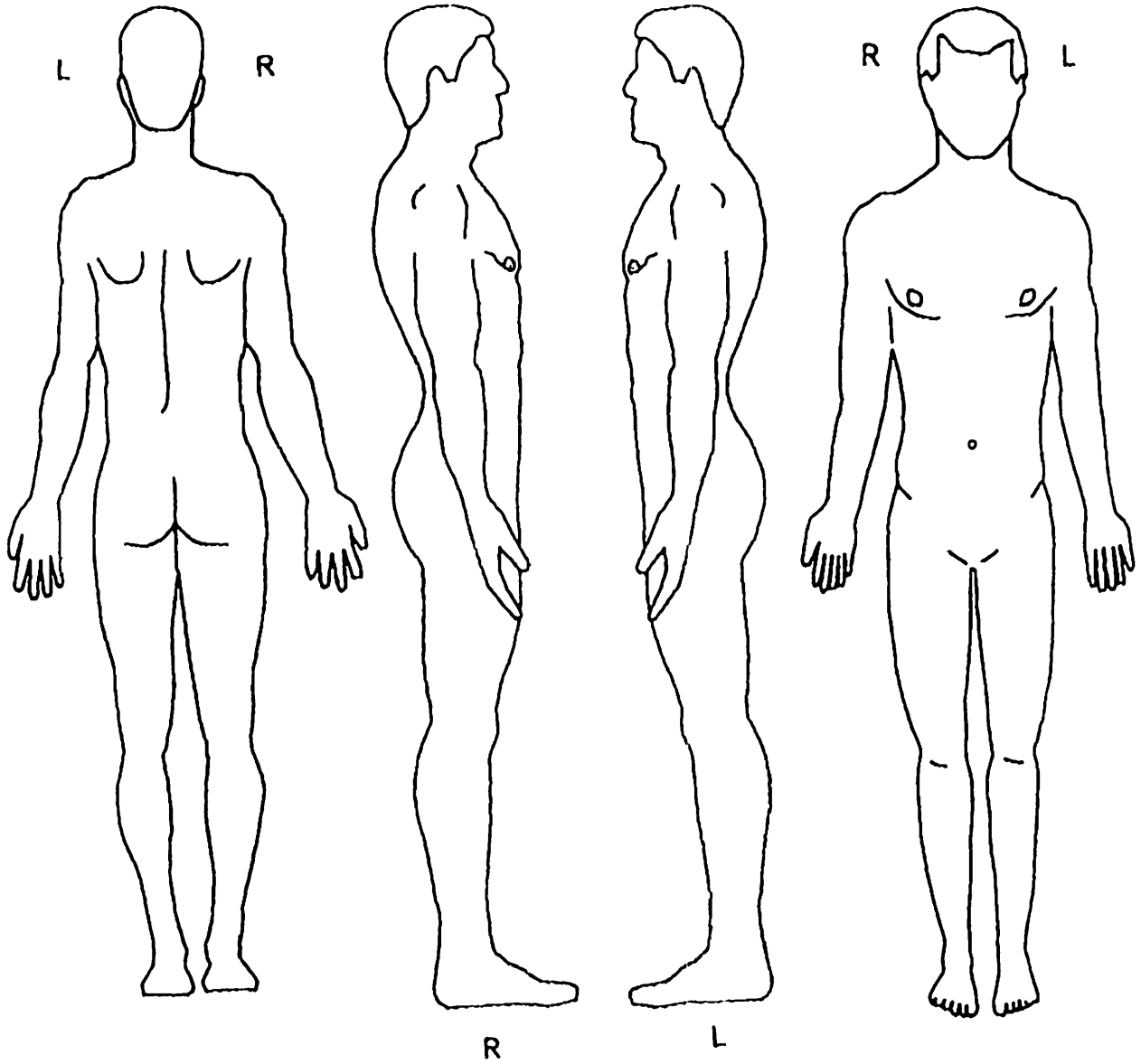
Patient's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Reviewed Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

# PAIN DRAWING

NAME \_\_\_\_\_ DATE \_\_\_\_\_



Mark as follows:

A - Ache B - Burning N - Numbness P - Pins & Needles

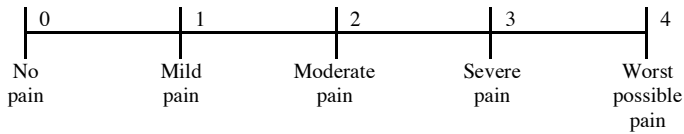
S - Stabbing O - Other - Describe \_\_\_\_\_

# Functional Rating Index

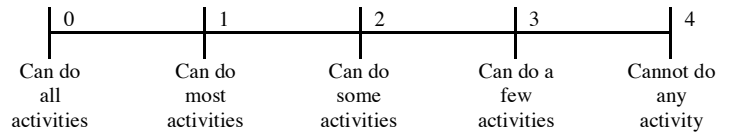
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

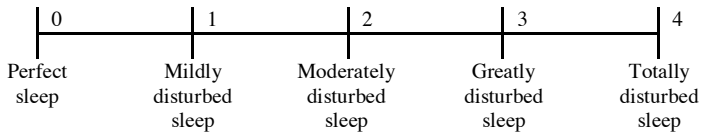
## 1. Pain Intensity



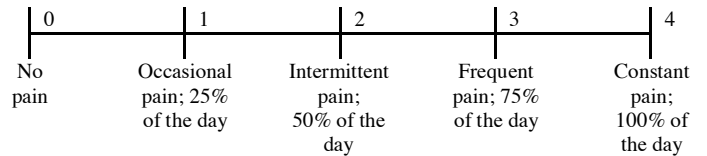
## 6. Recreation



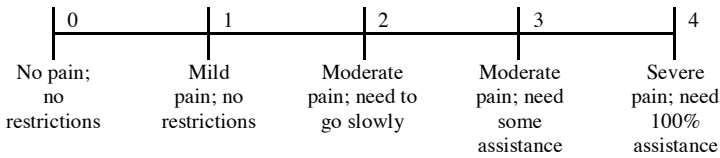
## 2. Sleeping



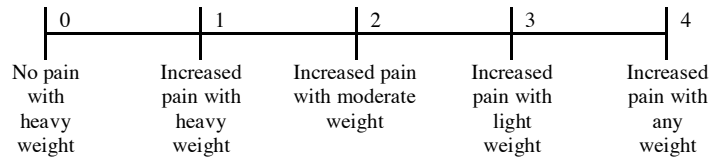
## 7. Frequency of Pain



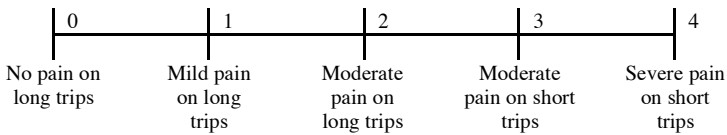
## 3. Personal Care (washing, dressing, etc.)



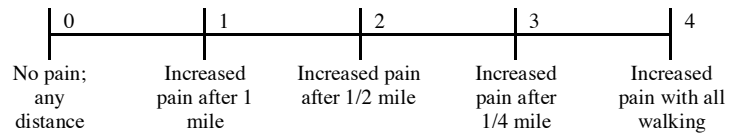
## 8. Lifting



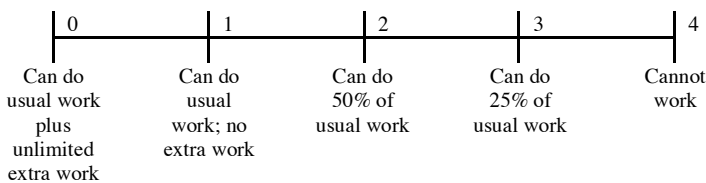
## 4. Travelling (driving, etc.)



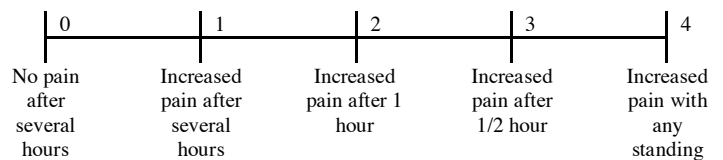
## 9. Walking



## 5. Work



## 10. Standing



\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

**Office Use Only**

Clinical Diagnosis Codes: \_\_\_\_\_

Total Score: \_\_\_\_\_ / 40

Doctor's Signature and Date: \_\_\_\_\_

**2014 CARDIOVASCULAR EXAM AND SCREENING QUESTIONNAIRE**

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Gender:

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<br>(ic. temporary loss of vision, blind spots, floaters)? | _____ | _____ |
| 17. Do you suffer from diabetes?  | _____ | _____ |
| 18. Do you have any swollen or stiff joints?  | _____ | _____ |



**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

**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.

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