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

Driver's 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 phoneprovider? _____

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

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:

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

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

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

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 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 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.

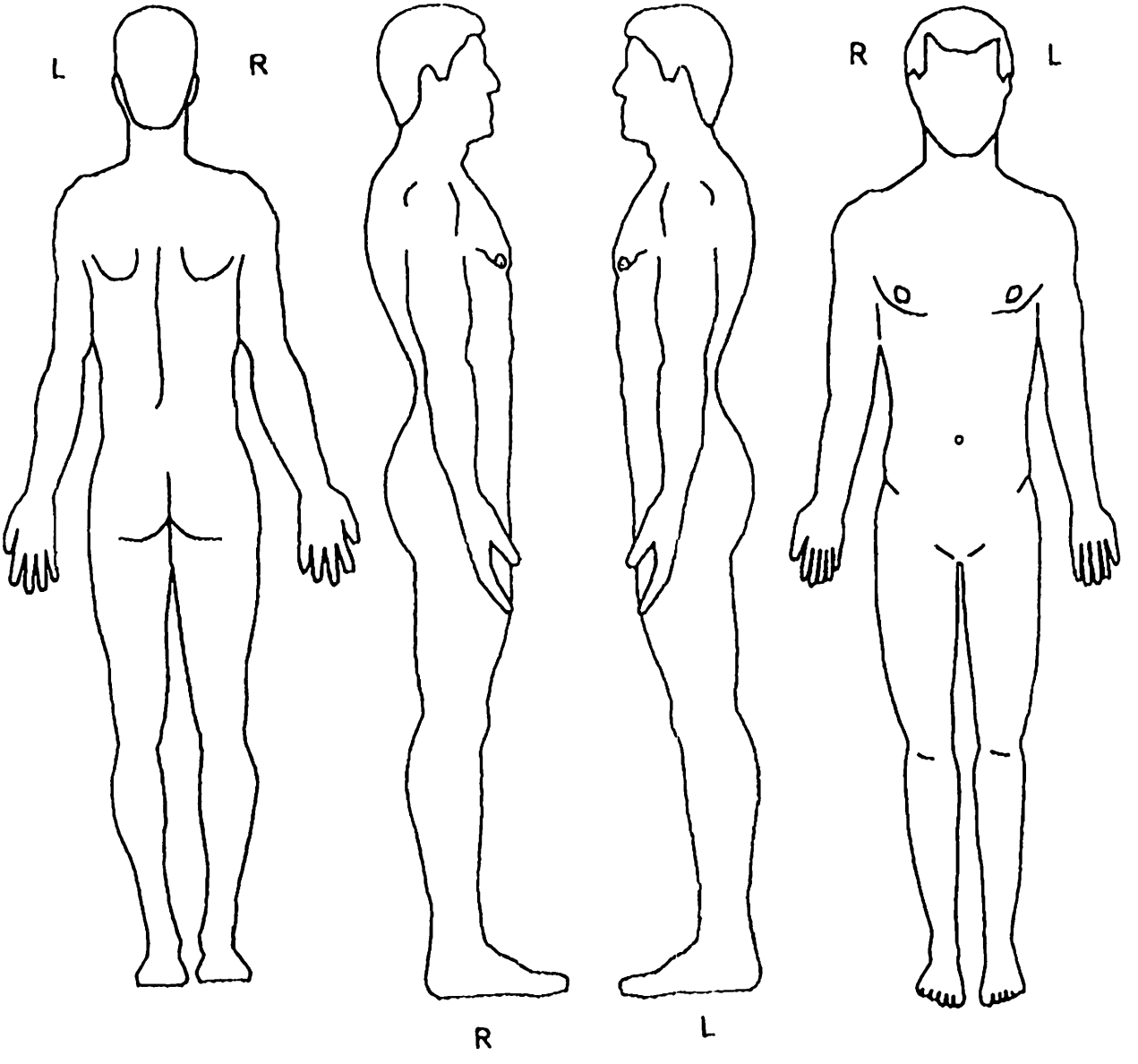
Patient's / Guardian's Signature_____Date_____

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 _____

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

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

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_____

LIFETIME AUTHORIZATION ASSIGNMENT OF BENEFITS AND INSURANCE RELEASE

I certify chat 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 faces that are important. Thereby authorize Advanced Medical and Rehab of Miami, Inc, Chiropractic Associates Inc, Advanced Physical Medicine & Rehab of Miami Inc, and Physical Therapy Professional Center, 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, Chiropractic Associates Inc, Advanced Physical Medicine & Rehab of Miami Inc, and Physical Therapy Professional Center, Inc. I hereby authorize Advanced Medical and Rehab of Miami, Inc, Chiropractic Associates Inc, Advanced Physical Medicine & Rehab of Miami Inc, and Physical Therapy Professional Center, 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 char 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, Chiropractic Associates Inc, Advanced Physical Medicine & Rehab of Miami Inc, and Physical Therapy Professional Center, 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 arc 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 of Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

Provider: Advanced Physical Medicine & Rehab of Miami, Inc.
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