Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home #: (_____)_____-_____ Cell #: (_____)_____-_____ Work #: (_____)_____-_____

SS#: ___ - ___ - _____ Age: _____ DOB: __ __ / __ __ / __ __ __ __ Male / Female

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone

Occupation: _____ Employer: _____

Type of Tasks Performed/Common Movements: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENT

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐ Last Visit: _____

REFERRAL

How Did You Hear About This Office?

☐ Radio: _____ ☐ Existing Patient: _____ ☐ Walk-In/Drive-By

☐ Ad: _____ ☐ Internet: _____ ☐ Shapes

☐ Massage-A-Teacher: _____ ☐ Community Event: _____ ☐ Lifestyles

☐ Other: _____ ☐ Insurance Comp.

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment & Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, *Physical Medicine Associates of Gainesville, LLC*, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether paid by insurance, or not. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of care.)

Signature (x): _____ **Date:** _____/_____/_____

Medical History

WHAT IS THE PRIMARY PROBLEM YOU WOULD LIKE ADDRESSED TODAY? _____

_____

_____

PATIENT PAST/CURRENT MEDICAL HISTORY: *please check if you have ever had any of the following:*

- ❑ Aids/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low
- ❑ Broken Bones
- ❑ Cancer
- ❑ Contact/Glasses
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Prosthesis
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Whooping Cough
- ❑ Other: _____

_____

_____

Are you currently under medical care? If yes, with whom and for what conditions?

_____

_____

Please list any and all prescribed medication you are taking (or submit a list if possible):

_____

_____

Please list any supplements you are currently taking, including vitamins, minerals, etc.:

_____

_____

Allergies: _____

Please list any surgeries and/or hospitalizations you have had (type and date if possible):

_____

_____

Is there a family history of any of the following conditions? Includes grandparents, parents, siblings, etc.

❑ Heart Disease _____ ❑ Diabetes _____

❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x / Week ❑ 3-4x / Week ❑ 1-2x / Week ❑ Occasionally ❑ None

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 Cigarettes _____ packs/day

FOR FEMALES ONLY: Is there any chance you could be pregnant? ❑ Yes ❑ No

When was your last period? _____

Patient Name: _____ Date: _____/_____/_____

PAIN DISABILITY QUESTIONNAIRE

Instructions: These questions ask your views about how your pain **right now** affects body function in everyday activities. Please answer every question on this form and mark an **"X"** on **ONE** number on each question/scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unable to Work

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of self
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Need help with care

3. Does your pain interfere with your traveling?
   Able to travel
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Only travel to see Doctors

4. Does your pain affect your ability to sit or stand?
   No problems
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unable to sit/stand

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?
   No problems
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unable to perform

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unable to perform

7. Does your pain affect your ability to walk or run?
   No problems
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unable to perform

8. Has your income declined since your pain began?
   No decline
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Loss of all income

9. Do you have to take pain medication every day to control your pain?
   No med needed
   0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Take meds throughout day

10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Total interference

13. Do you need the help of your family and friends to complete everyday tasks (including both work inside and outside the home and housework) because of your pain?
    Never need help
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Need help all the time

14. Do you feel more depressed, tense or anxious than before your pain began?
    No depression/tension
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Severe depression/tension

15. Are there emotional problems caused by your pain that interfere with your family, social and/or work activities?
    No problems
    0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Severe problems

Reviewed by: _____ Date: _____/_____/_____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Physical Medicine Associates of Gainesville, LLC, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Ms. Traci Davis. If you would like further information about our privacy policies and practices please contact: Ms. Traci Davis.

This notice is effective as of August 1, 2016. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____/_____/_____

Name (Print) *Signature (x)* *Date(mm/dd/yyyy)*

List Below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

Physical Medicine Associates of Gainesville, LLC
3703 SW 13th Street · Gainesville, FL 32608
*Phone: **352.378.7664** Fax: 352.373.0111*

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Physical Medicine Associates of Gainesville, LLC to provide medical care and/or administer diagnostic and/or therapeutic procedures and treatments per the decision of the healthcare provider in attendance which are deemed necessary and advisable. It is my responsibility to make known any and all contraindications to care I may have and I assume all responsibility/liability if I do not report my past medical history, illnesses, medicines, allergies or any health issues that may interfere with my care.

I understand that Physical Medicine Associates of Gainesville, LLC does not perform breast, pelvic, prostate, rectal or full skin evaluations. This office also does not provide traditional care for any medical conditions other than those addressed by my treatment plan. I acknowledge that they do not prescribe nor refill ANY controlled substances and will only prescribe medications that are deemed necessary to complement my care.

Furthermore, I do not expect the healthcare providers of Physical Medicine Associates of Gainesville, LLC to be able to anticipate all risks and complications associated with the kind of medical care being provided and wish to rely upon them to exercise their best judgement during said course of care. This includes the history and physical exam, any diagnostic tests ordered and any procedures deemed necessary and in my best interest. I have had the opportunity to discuss the nature, purpose and risks of medical treatment and procedures provided by Physical Medicine Associates of Gainesville, LLC and have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation for medical treatment and have been informed and weighed the risks involved in such care at this office. I have decided that it is in my best interest to receive care provided by Physical Medicine Associates of Gainesville, LLC and I hereby give my consent to that treatment. I understand that this consent will cover the entire course of treatment for my present condition(s) and for any future conditions for which I seek treatment. I also understand that a procedure consent form will be signed on the day of every procedure and further risks may be discussed as necessary at that time. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration guidelines and current malpractice terms.

The below signature signifies my understanding of this consent and agreement to the above.

_____ _____/_____/_____
Printed Name of Patient Date

_____ _____/_____/_____
Signature of Patient or Representative Date

_____ _____/_____/_____
Witness to Signature Date