

Non Surgical Center for Physical & Sports Medicine

PATIENT INFORMATION

DATE: _____
REFERRED BY: _____
LAST NAME: _____ FIRST NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____
ZIP: _____ TELEPHONE #: _____
DATE OF BIRTH: _____ AGE: _____ SEX: _____
S.S. #: _____ MARITAL STATUS: S M W D SEP
EMPLOYER: _____ PHONE #: _____
EMERGENCY CONTACT: _____ PHONE #: _____
RELATION: _____ PRIMARY LANGUAGE: _____

MEDICAL HISTORY

CURRENT MEDICAL PROBLEM: _____
DAT OF ONSET/INJURY: _____ WAS THIS AN ACCIDENT: YES NO
PRIMARY PHYSICIAN: _____

**IS PATIENT RESPONSIBLE PARTY: YES NO
IF NO COMPLETE RESPONSIBLE PARTY INFORMATION**

NAME OF RESPONSIBLE PARTY: _____
ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____
POLICY HOLDER: _____ POLICY HOLDER: _____
ID#: _____ ID#: _____
GROUP #: _____ GROUP #: _____

NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE

HEALTH QUESTIONNAIRE

HOSPITAL ADMISSIONS

YEAR	ILLNESS OR OPERATION

MEDICATIONS (INCLUDING OVER THE COUNTER MEDICATIONS)

NAME	STRENGTH	HOW OFTEN

ALLERGIES: _____

FAMILY HISTORY

	AGE	ALIVE (Y/N)	IF DECEASED, CAUSE OF DEATH	DISEASES
FATHER				
MOTHER				
BRO/SIS				
BRO/SIS				
BRO/SIS				
MOTHER'S RELATIVES				
FATHER'S RELATIVES				

MEDICAL HISTORY

MAIN PROBLEMS: 1) _____ **2)** _____ **3)** _____

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Decreased Hearing
<input type="checkbox"/> Ringing in ear
<input type="checkbox"/> Ear infections
<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Failing vision
<input type="checkbox"/> Double vision
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Eye infections
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Hayfever- Allergies
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis/Cough
<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Palpitation
<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Leg pain
<input type="checkbox"/> Varicose veins | <input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Indigestion/Heartburn
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Change in bowel habits
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Hernia
<input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Urine infections
<input type="checkbox"/> Painful urination
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Chronic fatigue
<input type="checkbox"/> Weight loss | <input type="checkbox"/> Anemia
<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tremor
<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Headaches
<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Gout
<input type="checkbox"/> Back pain
<input type="checkbox"/> Bone fracture/Joint injury
<input type="checkbox"/> Foot pain
<input type="checkbox"/> Rashes
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Eczema
<input type="checkbox"/> Sleeping difficulty
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Phobias
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Recent hair loss | <input type="checkbox"/> Herpes
<input type="checkbox"/> Shingles
<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Measles
<input type="checkbox"/> Polio

Social History:
<input type="checkbox"/> Smoking _____ packs/cigs per day
<input type="checkbox"/> Alcohol _____ drinks per day/week
<input type="checkbox"/> Coffee/Tea _____ drinks per day/week

Females:
<input type="checkbox"/> Menstrual problems
<input type="checkbox"/> Menopause
<input type="checkbox"/> Birth control/Method _____
Number of Pregnancies _____
Number of Miscarriages _____ |
|---|--|--|--|

NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE

ASSIGNMENT, LIEN & AUTHORIZATION

I hereby authorize and direct you, my insurance company, and/or my attorney, to assign my benefits and pay directly to NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE, INC., such sums as may be due and owing them for services rendered me, both by reason of accident or illness, and to withhold such sums from any disability, medical payment benefits, no fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement judgment or verdict on my behalf as may be necessary to adequately protect said office.

I understand that I remain personally responsible for the total amounts due the above mentioned office for services rendered. I further understand and agree that this directive, lien and authorization does not bind this office into waiting for payment from my insurance company, and that they may demand from me, at any time, payment for services rendered if my insurance company does not honor this agreement or pay their obligation as the had agreed.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this directive, lien and authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of services rendered.

Furthermore, in the event that my insurance company sends payment(s) directly to me (contrary to my directive and authorization above), I agree to present said payment in its original draft within 7 (seven) days of receipt to NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE, INC. If I fail to present said payment(s) within 7 (seven) days, I agree to pay 18% annum interest (1 ½% per month) on said payments.

If it is deemed necessary for the above mentioned office to pursue collection activities for any monies owed them, I agree to pay the cost of said collections, including court costs, attorney's fees and any other costs of litigation that may be incurred.

This agreement is irrevocable. A photocopy of this document is as good as the original.

I have read the above and understand it.

_____, Florida

_____, 20__

Patient's Signature

Print Name

Witnessed

NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE

MEDICAL RECORD RELEASE

Date: _____

Name of Patient: _____

Date of Birth: _____

TO WHOM IT MAY CONCERN

You are hereby authorized to release all medical records, including sensitive information such as mental health related records, drug/alcohol diagnosis and treatment, HIV/AIDS related information to:

NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE

6766 WEST SUNRISE BLVD., SUITE 100A

PLANTATION, FL 33313

FAX: (954) 316-4969

Patient Signature: _____

Witness: _____

PATIENT CONSENT FORM

THE NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE
CHAD E. FRANK, D.O.
6766 WEST SUNRISE BLVD., SUITE 100A
PLANTATION, FL 33313
TELEPHONE (954) 316-4905

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME _____ DATE _____

SIGNATURE _____

I AUTHORIZE THIS OFFICE TO GIVE THE FOLLOWING PERSONS INFORMATION REGARDING MY TREATMENT, DIAGNOSIS AND OR BILLING CONCERNS.

NAME	RELATIONSHIP TO PATIENT
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NAME	RELATIONSHIP TO PATIENT
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**NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE
PAIN MANAGEMENT AGREEMENT**

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Dr. Chad E. Frank not providing ongoing care for me.

I agree to the following statement:

- I will not accept any opioid medication prescriptions from another doctor.
- I will be responsible for making sure that I do not run out of my medications on weekends and holidays because abrupt discontinuation of these medications will cause severe withdrawal symptoms.
- I understand that I must keep my medications in a safe place.
- I understand that Dr. Chad E. Frank will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.
- I agree that I will take my medications as prescribed, at a no greater rate than what is prescribed.
- I will not give my prescriptions and/or medications to anyone else.
- I will only use one pharmacy.
- I will keep my scheduled appointments with Dr. Chad E. Frank
- I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by Dr. Chad E. Frank.
- I agree that I will submit to a blood or urine test if requested by the doctor to determine compliance with pain control medications.
- I will bring all unused medication to every office visit or home visit.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to these authorizations.

Termination Clauses

- A. The doctor may terminate this agreement at any time if he has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
- B. I understand that I may terminate this agreement at any time.

I agree to use _____ pharmacy

located at _____

telephone number _____ for filling all of my pain medicine.

If the agreement is terminated, I will not be a patient of Dr. Chad E. Frank and would strongly consider treatment for chemical dependency if clinically indicated.

Patient signature _____ Date _____

Physician signature _____ Date _____

Witness signature _____ Date _____