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)________________________________

☐Decreased Hearing
☐ Ringing in ear
☐Ear infections
☐Dizzy spells
☐Failing vision
☐Double vision
☐Blurred Vision
☐Eye infections
☐Glaucoma
☐Cataracts
☐Sinusitis
☐Nose bleeds
☐Sore throat
☐Hayfever- Allergies
☐Pneumonia
☐Bronchitis/Cough
☐Asthma/Wheezing
☐Shortness of breath
☐Chest Pain
☐High blood pressure
☐Heart murmur
☐Palpitation
☐Swollen ankles
☐Leg pain
☐Varicose veins

☐Loss of appetite
☐Difficulty swallowing
☐Indigestion/Heartburn
☐Nausea/Vomiting
☐Ulcers
☐Abdominal pain
☐Change in bowel habits
☐Diarrhea
☐Constipation
☐Diverticulosis
☐Blood in stools
☐Hemorrhoids
☐Hernia
☐Gallbladder trouble
☐Jaundice
☐Hepatitis
☐Urine infections
☐Painful urination
☐Blood in urine
☐Frequent Urination
☐Incontinence
☐Kidney stones
☐Sexually transmitted disease
☐Chronic fatigue
☐Weight loss

☐Anemia
☐Bruise easily
☐Cancer
☐Diabetes
☐Thyroid disease
☐Seizures/Convulsions
☐Stroke
☐Tremor
☐Numbness/Tingling
☐Headaches
☐Arthritis/Rheumatism
☐Gout
☐Back pain
☐Bone fracture/Joint injury
☐Foot pain
☐Rashes
☐Psoriasis
☐Eczema
☐Sleeping difficulty
☐Depression
☐Anxiety
☐Mental Illness
☐Phobias
☐Memory loss
☐Recent hair loss

☐Herpes
☐Shingles
☐Chicken pox
☐Measles
☐Polio

Social History:
☐Smoking_____packs/cigs per day
☐Alcohol _____drinks per day/week
☐Coffee/Tea ____ drinks per day/week

Females:
☐Menstrual problems
☐Menopause
☐Birth control/Method __________
Number of Pregnancies_____
Number of Miscarriages_____

MEDICARE SIGNATURE ON FILE

I require that payment of authorized Medicare benefits be made on my behalf to:

Non Surgical Center for Physical & Sports Medicine, Inc.
Chad E. Frank, D.O.
6766 West Sunrise Blvd., Suite 100A
Plantation, Florida 3313

for any services furnished to me by the listed provider: I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) Centers for Medicare and Medicaid Services (CMMS) and its agents any information needed to determine these benefits for the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare- assigned cases, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare- assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non- covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print): ____

PATIENT'S SIGNATURE: ____

PATIENT'S MEDICARE #: ____

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

____
NAME RELATIONSHIP TO PATIENT

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 mad 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 ___________________________________