



THE NON SURGICAL CENTER FOR PHYSICAL AND SPORTS MEDICINE

PATIENT INFORMATION

DATE: _____

REFERRED BY: _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

SOICAL SECURITY: _____ MARTIAL STATUS: S M W D SEP

EMPLOYER: _____ PHONE #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RELATION: _____ PRIMARY LANGUAGE: _____

MEDICAL HISTORY

CURRENT MEDICAL PROBLEM: _____

DATE OF ONSET/ INJURY: _____ WAS THIS AN ACCIDENT: YES NO

PRIMARY PHYSICIAN: _____ TELEPHONE #: _____

IS THIS PATIENT RESPONSIBLE PARTY: YES NO

IF NO COMPLETE RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY: _____ D.O.B. _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

POLICY HOLDER: _____ POLICY HOLDER: _____

MEMBER ID: _____ MEMBER ID: _____

GROUP #: _____ GROUP #: _____



HEALTH HISTORY QUESTIONNAIRE

List any medical problems that other doctors have diagnosed

Hospitalizations or Operations		
Year	Reason	Hospital

Medications (Including over the counter medications)		
Name	Strength	Frequency taken

Allergies:

Family History	Age	Alive (Y/N)	Diseases
Father			
Mother			
Sister/Brother			
Sister/Brother			
Mother's Relatives			
Father's Relatives			

Medical History

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

- Females: Menstrual problems
 Menopause
 Birth control/ method ___
 Number of pregnancies ___
 Number of miscarriages ___

- Social History:
 Smoking ___ packs/ cigarettes per day
 Alcohol ___ drinks per day/ week
 Coffee/ Tea ___ drinks per day/ week



Patient Consent Form

THE NON SURGICAL CENTER FOR PHYSICAL AND SPORTS MEDICINE, INC.
DR. CHAD E. FRANK, D.O.
6710 W. SUNRISE BLVD., SUITE 110
PLANTATION, FL 33313
(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 the 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 below 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 and health care operations. 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 _____



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 and Sports Medicine, INC.
6710 W. Sunrise Blvd., Suite 110
Plantation FL. 33313
Tel. (954) 316-4905
Fax (954) 316-4969*

Patient Signature: _____

Witness: _____



PAIN MANAGEMENT AGREEMENT

I understand that I have the 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 statements:

I will not accept any narcotic prescriptions from another doctor.

I will be responsible for making sure that I do not run out of 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 not supply additional refills for prescriptions of medications that I may lose.

If my medications are stolen, Dr. Chad E. Frank will refill the prescription one time only if a copy of a police report of the theft is submitted to the physician's office.

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.

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 or confidentiality with respect of these authorizations.

Termination Clauses

- A. The doctor may terminate this agreement at any time if he 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 compliance with the terms of 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 _____



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 payments benefits, no fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement judgement 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 the 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 they 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 the 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 days of receipt to Non-Surgical Center for Physical and Sports Medicine, INC.

If it is deemed necessary for the above mentioned office to pursue collection actives 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 signature

Print name

Witnessed



Dr. Frank is an independent physician who values his patients' time. Quality care is given to every patient and the practice depends on its clients through referrals, word of mouth or advertising to continue to perform at a high quality level.

Every time slot is very important to both our clients and Dr. Frank.

When clients do not show up for their appointments, it takes that time away from another and away from the business which is necessary to continue to provide the highest quality care.

For this reason, please extend the courtesy of giving at least

24 HOURS NOTICE

in cancelling appointments or a

\$50 DOLLAR NO SHOW FEE

will apply.

Patient Signature _____