THE NON SURGICAL CENTER FOR PHYSICAL & SPORTS MEDICINE

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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 INSURACE: ____________________ SECONDARY INSURANCE: ____________________

POLICY HOLDER: ____________________ POLICY HOLDER: ____________________

MEMBER ID: ____________________ MEMBER ID: ____________________

GROUP #: ____________________ GROUP #: ____________________

6710 W. Sunrise Blvd., Suite 110, Plantation, FL 33313
Phone: 954-316-4905 | Fax: 954-316-4969
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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

- ☐ Decreased hearing
- ☐ Ringing in the ear
- ☐ Ear infections
- ☐ Dizzy spells
- ☐ Failing vision
- ☐ Double vision
- ☐ Blurred vision
- ☐ Eye infections
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Sinusitis
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hay fever- Allergies
- ☐ Pneumonia
- ☐ Bronchitis/ Cough
- ☐ 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 habit
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Gallbladder trouble
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Urine infections
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Joint injury
- ☐ Chronic fatigue
- ☐ Weight loss
- ☐ Bruise easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Seizures/ Convulsions
- ☐ Stroke
- ☐ Tremor
- ☐ Numbness/ Tingling
- ☐ Headaches
- ☐ Arthritis/ Rheumatism
- ☐ Gout
- ☐ Back pain
- ☐ Bone fracture
- ☐ Sexually transmitted disease
- ☐ Foot pain
- ☐ Rashes
- ☐ Eczema
- ☐ Depression
- ☐ Anxiety
- ☐ Mental illness
- ☐ Phobias
- ☐ Memory loss
- ☐ Recent hair loss
- ☐ Herpes
- ☐ Shingles
- ☐ Chicken Pox
- ☐ Measles
- ☐ Polio

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

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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 information 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

THE NON SURGICAL CENTER
FOR
PHYSICAL & SPORTS MEDICINE

MEDICAL RECORD RELEASE

DATE: ______________________________

NAME OF PATIENT: ____________________________________

DATE OF BIRTH: ____

TO WHOM IT MAY CONCERN

You are here by 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: ____

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THE 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 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

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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____________

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MEDICARE SIGNATURE ON FILE

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

Non- Surgical Center for Physical and Sports Medicine, INC.
Chad E. Frank, D.O.
6710 W. Sunrise Blvd., Suite 110
Plantation, FL. 33313

For any services furnished to me by the listed provider. I authorize any holder for 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 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, the prover 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.

PATIENTS NAME (print): ______________________________

PATIENTS SIGNATURE: ______________________________

PATIENTS MEDICARE ID NO.: ______________________________

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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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 ______________________________

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