

**Advanced PMR
Major Medical/Medicaid/Medicare Patient Intake**

GENERAL INFORMATION

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Birth Date: ____/____/____ Social Security #: _____ - _____ - _____ Marital Status:
S M D W Drivers License Number and State issued _____ State _____
As a convenience to our patients, we offer appointment reminders through emails and text messages.
Would you like to be set up on automatic text reminders? Yes No If yes, who is your cell phone
provider? _____

ACCIDENT INFORMATION

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other
Date of Accident _____ Has the accident been reported? Yes No
To Whom? _____ Claim Number _____

HEALTH INSURANCE INFORMATION

Name of Your Health Insurance Co. _____
Policy # _____ Group # _____
Insured's Name if different than yours _____ Insured's SS# ____/____/____
Relationship to Insured _____ Insured's Birth date ____/____/____
Employer _____

SECONDARY INSURANCE INFORMATION

Name of Your Health Insurance Co. _____ Policy # _____
Group # _____ Insured's Name if different than yours _____
Insured's SS# ____/____/____ Relationship to Insured _____
Insured's Birth date ____/____/____ Employer _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor _____ Date _____

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Eczem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you are currently experiencing any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt | _____ |

Are you currently pregnant? Yes No

Are you currently under drug and/or medical care? Yes No

If yes, explain _____

Please list any medications you are currently taking (Be sure to include dosage and frequency)

Please list any surgeries and/or hospitalizations you have had (type & date)

If you are male, when was your last prostate exam? _____

Normal prostate results? _____

Please list any supplements you are currently taking (vitamins, minerals, herbs) _____

Are you currently on any blood thinners – (aspirin regimen included)? Yes No

List Type _____

Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.

Please CHECK if you have any of the following: Type 2 Diabetes Sleep Apnea High Cholesterol

A pacemaker Suffer from blood clots Local or systemic infection Allergies (please list)

_____ Atria Fibulation Uncontrolled Hypertension Glaucoma Rapid Heartbeat

Severe Depression Uncontrolled clotting disorder Renal Disease Pregnant/Breast Feeding History

of Stroke Hyperthyroid History of Drug/Alcohol Abuse Is there a family history of any of the

following conditions? (Indicate family member including parents, grandparents & siblings) Heart Disease

_____ Diabetes _____ Stroke _____ Cancer

_____ Arthritis _____ Other _____

Do you exercise?: Yes No How often?: 1X 2X 3X 4X 5X per week Other: _____

Which activities: Running Jogging Weight Training Cycling Yoga Pilates Swimming Other

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 Energy Drinks _____ cups/day Cigarettes _____ packs/day

I hereby certify that the previous questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature _____ Date _____

Doctor Reviewed Signature _____ Date _____

Doctor Updated Signature _____ Date _____

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Advanced Physical Medicine & Rehab and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial) Signature of Patient/or

Guardian of said Minor _____ Date _____

AUTHORIZATION OF CARE

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services)

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Name Printed _____

Date _____

Patient's signature _____

Date _____

Minors Name _____

Guardian/Spouse's Signature of Authorizing care for minor _____

Date _____

I hereby authorize Advanced Physical Medicine & Rehab to administer care as deemed necessary to my child, a minor under the age of 18 years old.

EMERGENCY CONTACT

Name _____ Work Phone _____

Relationship _____ Home Phone _____

Cell Phone _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT (CONSENT TO USE PHI)

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Advanced Physical Medicine & Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____

Date _____

Print Patient's Full Name _____

Time of Day _____

Witness Signature _____

Date _____