Multi-Care Medical
OF VERO BEACH

880 37TH PL. UNIT 105 VERO BEACH, FL 32960 PH (772) 617-6795 FX (772)617-6796

ABOUT YOU:

TODAY'S DATE: _____PATIENT NAME:_____

SEX: ___MALE___FEMALE D/O/B: _____ AGE: _____ SS#: _____

ADDRESS: _____CITY/ST/ZIP: _____

CONTACT #: _____EMAIL: _____@_____.COM

I authorize to receive email/text messages for appointment reminders and general health reminders from this practice _____(PT INITIALS)

EMPLOYER: _____OCCUPATION: _____

STATUS: ___MINOR ___SINGLE ___MARRIED ___DIVORCED ___SEPARATED ___WIDOWED

SPOUSE: _____CHILDREN: ___YES ___NO IF SO, HOW MANY? ____

EMERGENCY CONTACT:

NAME: _____RELATION: _____PH #: _____

If a family member/friend asks to speak to you, can we tell them you are here: ___YES ___NO

REASON FOR YOUR VISIT:

REASON FOR THE VISIT: ____AUTO ____WORK ____SPORTS ____TRAUMA ____CHRONIC

EXPLAIN WHAT HAPPENED IN DETAIL:_____

DESCRIBE THE PAIN AND LOCATION: _____

DATE CONDITION BEGAN: _____|GETTING WORSE: ____Y____N|CONSTANT: ____COMES/GOES:____

IS THE CONDITION INTERFERRING WITH YOUR: _____WORK _____SLEEP _____DAILY ROUTINE

HAVE YOU HAD A SIMILAR CONDITION IN THE PAST? _____YES _____NO

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN? _____YES _____NO

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? _____YES _____NO WHOM?_____

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HEALTH HISTORY:

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

___BLOOD PRESSURE ___PAIN KILLERS (ASPIRIN) ___MUSCLE RELAXERS ___BLD THINNERS

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

	HEART ATTACK/STROKE		HEART SURG/PACEMAKER		HEART DISEASE
	ALCOHOL ABUSE		DRUG ABUSE		HIV/AIDS
	SHINGLES		VENEREAL DISEASE		DIABETES
	CANCER_____		SINUS PROBLEMS		GLAUCOMA
	RESPIRATORY ISSUES		KIDNEY PROBLEMS		ARTHRITIS
	ANEMIA		ASTHMA		HIGH / LOW BLOOD PRESS.
	HEPATITIS		FAINTING / SEIZURES		ULCER / COLITIS
	PSYCHIATRIC PROBLEMS		OTHER		_____

DO YOU HAVE ANY METAL IN YOUR BODY? (EX. BULLETS, IMPLANTS) ___YES ___NO ;
IF YES, PLEASE EXPLAIN: _____

LIST ANY SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD:

_____

PLEASE LIST ANYTHING YOU MAY BE ALLERGIC TO:

_____

LIST PREVIOUS SURGERIES/TREATMENTS WITH DATES:

_____

LIST ANY PAST SERIOUS ACCIDENTS WITH DATES:

_____

FAMILY HEALTH HISTORY (CANCER, HIGH BLOOD PRESSURE/HEART DISEASE) ETC:

_____

SOCIAL HISTORY:.

DO YOU TAKE SUPPLEMENTS OR VITAMINS?	___YES	___NO
EXERCISE?	___YES	___NO
SPECIAL DIET?	___YES	___NO
DO YOU SMOKE?	___YES	___NO

WOMEN:

PREGNANT?	___YES	___NO
LAST MENSTRUAL CYCLE?	___YES	___NO

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ACCIDENT:

DATE|TIME OF ACCIDENT: _____@_____ AM / PM

DID YOU FILE A REPORT? : ☐YES ☐NO WITNESSES? ☐YES ☐NO

NAME AND LOCATION WHERE INCIDENT OCCURRED AND DETAILS?_____

_____

AFTER THE ACCIDENT:

WERE YOU RENDERED UNCONSCIOUS? ___YES ___NO IF YES, FOR HOW LONG? _____

PLEASE DESCRIBE HOW YOU FELT AFTER THE ACCIDENT: _____

HOSPITAL? ___YES ___NO AMBULANCE? ____YES ____NO IF YES, WHERE? _____

WHEN DID YOU GO? _____**AFTER ACCIDENT** _____**NEXT DAY** _____2+ DAYS

X-RAYS? YES NO **CT SCAN?** YES NO

☐	DIZZINESS	☐	___MEMORY LOSS___BLURRED VISION	☐	HEADACHES	☐	BUZZING/RINGING IN EAR(S)
☐	NECK PAIN / STIFFNESS	☐	NUMB: ARM HANDS FINGERS	☐	SHOULDER PAIN ____L ____R	☐	ELBOW PAIN ___L ___R
☐	WRIST / HAND ___L ___R	☐	UPPER BACK PAIN	☐	CHEST PAIN	☐	MID BACK PAIN
☐	LOWER BACK PAIN	☐	NUMB LEGS ____FEET____ L___R___	☐	LEG PAIN L___R___	☐	KNEE PAIN L___R___
☐	FOOT / ANKLE PAIN L____R____	☐	DIFFICULTY SLEEPING	☐	NAUSEA	☐	OTHER _____

INDICATE YOUR DEGREE OF COMFORT WHILE PERFORMING THE FOLLOWING ACTIVITIES:

		COMFORTABLE	UNCOMFORTABLE	PAINFUL
LYING ON BACK		☐	☐	☐
LYING ON SIDE		☐	☐	☐
LYING ON STOMACH		☐	☐	☐
SLEEPING SITTING		☐	☐	☐
STANDING		☐	☐	☐
WALKING		☐	☐	☐
RUNNING		☐	☐	☐
SPORTS		☐	☐	☐
WORKING		☐	☐	☐
LIFTING		☐	☐	☐

HAVE YOU BEEN ABLE TO WORK? ___YES ___NO NUMBER OF HOURS IN A WORKDAY? _____

HAS YOUR WORK BEEN AFFECTED SINCE THE ACCIDENT? ___YES ___NO

WHILE IN RECOVERY, IS THERE LIGHT DUTY WORK YOU CAN REQUEST? ___YES ___NO

TO EVALUATE THE EFFECT THAT CONTINUING WORK WILL HAVE ON YOUR RECOVERY PLEASE COMPLETE:

☐	STANDING	☐	DRIVING	☐	OPERATE EQUIPMENT	☐	SITTING
☐	TWISTING	☐	WORK W ARMS	☐	WALKING	☐	CRAWLING
☐	LIFTING	☐	BENDING	☐	STOOPING	☐	OTHER_____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE:_____DATE:_____WITNESS:_____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to **Multi-Care Medical of Vero Beach**. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow **Multi-Care Medical of Vero Beach** to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify **Multi-Care Medical of Vero Beach** in writing within five days of receipt of this document. Failure to inform **Multi-Care Medical of Vero Beach** shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to **Multi-Care Medical of Vero Beach** and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then **Multi-Care Medical of Vero Beach** is directed to mail the patient/name insured a check, which represents the difference between the medical bills and the premiums paid.

DISPUTES: The insurer is directed by **Multi-Care Medical of Vero Beach** and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and **Multi-Care Medical of Vero Beach** hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by **Multi-Care Medical of Vero Beach** shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accords, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The pay claims at 200% of Medicare then the insurer is instructed & directed to provide **Multi-Care Medical of Vero Beach** with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. 673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination r examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to **Multi-Care Medical of Vero Beach**. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. **Multi-Care Medical of Vero Beach** is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I authorize **Multi-Care Medical of Vero Beach** to: furnish an insurer, an insurer's intermediary, the patient's other medical providers and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. **Multi-Care Medical of Vero Beach** is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from **Multi-Care Medical of Vero Beach** and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is direct to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing **Multi-Care Medical of Vero Beach** of any dispute.

I authorize **Multi-Care Medical of Vero Beach** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that **Multi-Care Medical of Vero Beach** be given a Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to results that may be obtained by any treatment or service; and I agree the provider's treatment and supplies are medically necessary and pertaining to my injuries. **Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient Name: _____ Patient Signature: _____Date:_____

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PHYSICIAN'S LIEN

To: Attorney_____
Re: Patient: _____ **Date of Accident:** _____

I hereby authorize the above doctor for furnish you, my attorney, with a full report of his examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to **Multi-Care Medical of Vero Beach** such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due office and withhold such sums from any settlement, judgment or verdict as may be necessary adequately to pay said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds from any settlement, judgment or verdict which may be paid to you, my attorney or myself a result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee.

Dated: _____ **Patient's Signature**_____

Address _____

The undersigned being attorney of record for the above patient does hereby agree to
Observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Dated: _____ **Attorney Signature:** _____

Attorney, please sign and return to doctor's office as soon as possible. Keep one copy for your records.

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi-Care Medical of Vero Beach** and/or the physicians of **Multi-Care Medical of Vero Beach** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above-named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi-Care Medical of Vero Beach** and/or the physicians of **Multi-Care Medical of Vero Beach**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Date: _____ Signed: _____

Witness: _____ Patient's Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 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 received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. 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 disclose to carry out treatment, payment or 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.

Patient Name: ______________________________

Relationship to Patient: ____ Self ____Other ______________________

Signature: ______________________________Date: _______

✣✣

OFFICE USE ONLY

WITNESS: ______________________________