Office Use Only

Pt# _____ DOB: _____

Elite Healthcare
Physical Medicine

PATIENT APPLICATION FORM

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance. We look forward to serving you.

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 certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important.

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.

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 (Print) Patient's Signature (Guardian, if Minor) Date

PATIENT INTAKE FORM

Patient Name: _____ Age: _____ Gender: M☐ F☐

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ / _____ / _____ Last 4 digits of Social Security #: _____ Marital Status: S M D W

Drivers License Number and State issued: _____ State: _____

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: _____

Spouse's Employer: _____ Occupation: _____

Who can we thank for referring you to our practice? _____

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 #: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Your Health Insurance Company: _____

Policy # _____ Group # _____

Insured's Name (if different than yours): _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Insured's Birth date _____/_____/_____ Employer: _____

PATIENT CONDITION

Reason for Visit:_____

When did your symptoms first appear?_____ Is your condition getting worse: □ Yes □ No

Rate the severity of your pain on a scale of 1 (least) to 10 (severe) _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling □Cramps □Stiffness □Swelling □Other

How many days in the last week did you feel the pain? _____

Does it interfere with your: □Work □Family Life □Sleep □Exercise □Recreation

Activities or movements that are painful to perform: □Sitting □Standing □Walking □Bending □Lying Down □Driving

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.

_____ _____

Patient/Guardian Signature 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:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Bowel/Bladder Changes
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Nausea
❑ Leg/Knee Pain L/R	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Cold Feet
❑ Headaches L/R	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Chest Pain
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑ Fever
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Hip Pain L/R	❑ Fainting

Please check to indicate if you have ever had any of the following:

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

❑ Other _____

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)

_____

Please list any allergies _____

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 should be avoided if patients have certain conditions. Please answer the following:

Do you have a pacemaker? ☐ Yes ☐ No Do you suffer from blood clots? ☐ Yes ☐ No Do you have knee/hip replacement? ☐ Yes ☐ No

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____ ☐ Other _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

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

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

Patient's / Guardian's Signature_____ Date_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

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 Elite Healthcare Physical Medicine, LLC. 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 _____ (Initials)

_____ _____

Patient/Guardian Signature Date

MEDICAL RECORDS RELEASE FORM

In order to provide the best care possible for you, we may share your medical records with your family doctor to let them know the progress you are making with our office.

I, _____ give Elite Healthcare Physical Medicine, LLC permission to share any and all medical records with my family doctor.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may revoke this authorization at any time by notifying the office. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Patient/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIC (HIPPA)

We understand that health information about you and your health is personal and we are committed to protecting your health information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

_____ _____

Patient/Guardian Signature Date

ASSIGNMENT OF BENEFITS/ ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I direct my insurance carrier or its intermediaries to issue payment directly to Elite Healthcare Physical Medicine, LLC. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co- insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original. By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

Patient Name (Print)	Patient Signature	Date

ASSIGNMENT OF BENEFITS for Medicare Patients Only

I request that payment of authorized Medicare benefits be made to me or on my behalf to Elite Healthcare Physical Medicine, LLC for treatment or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services for me to release it to the Center for Medicare/Medicaid Services and its agency. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

Patient Name (Print)	Patient Signature	Date