PPMRC
Physiatric Pain & Medical Rehab Clinic, P.A.

# New Patient Intake

| | | | |
|---|---|---|---|
| **Patient Name:** | | | **Date:** |
| **Gender:** ☐**M** ☐**F** | **Date of Birth:** | **Social Security Number:** | |
| **Street Address:** | | | |
| **City:** | | **State:** | **Zip:** |
| **Home:** | **Cell:** | | **Fax:** |
| **Email:** | | | |
| **Employer:** | | | **Phone:** |
| **Emergency Contact:** | | | **Phone:** |

## Medical Information

| | |
|---|---|
| **Do you Have Legal Representation?** ☐ Yes ☐ No **If so Name:** | |
| **Motor Vehicle Accident-** ☐ Yes ☐ No **Worker's Comp-** ☐ Yes ☐ No **Social Security Disability-** ☐ Yes ☐ No | |
| **Are you Right Handed or Left Handed?** ☐ **R** ☐ **L** | |
| **Date of Injury** | **Chief Complaint:** |
| **Explain in Great *Detail* How the Accident Occurred or how your *Pain* Started:** | |
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| *For Office Use Only* |
|---|
| Initials ____ Rm. # _____ |

| **Name:** | |
|---|---|
| **Today's Date:** | **When did your pain start?** |

➢ **Where is your pain located?**

**Rate your Pain 1-10**

| **Check:** | **Circle:** |
|---|---|
| ☐ **Low Back**__ | Left or Right___ |
| ☐ **Mid Back** __ | Left or Right___ |
| ☐ **Neck** __ | Left or Right___ |
| ☐ **Shoulder** __ | Left or Right___ |
| ☐ **Arm** __ | Left or Right___ |
| ☐ **Wrist & Hand** ___ | |
| ☐ **Hip** ____ | |

**Do Not forget to RATE your pain above** _____

_____

_____

➢ **When is your pain the worst?**

**Check all that apply:**

☐ **Morning** ☐ Daytime

☐ **Evening** ☐ Night

➢ **What makes the pain better?**

_____

_____

➢ **What makes the pain worse?**

_____

_____

**Can you describe your pain?**

**Check all that apply:**

| | |
|---|---|
| ☐ **Aching** | ☐ Burning |
| ☐ **Constant** | ☐ Intermittent |
| ☐ **Deep** | ☐ Dull |
| ☐ **Improving** | ☐ Increasing |
| ☐ **Numbness** | ☐ Shooting |
| ☐ **Pinching** | ☐ Pressure |
| ☐ **Sharp** | ☐ Stabbing |
| ☐ **Stiffness** | ☐ Tender |
| ☐ **Throbbing** | ☐ Tingling |
| ☐ **On and Off** | ☐ Localized |

☐ **Radiation (To: _____)**

➢ **Restrictions:**

**Are you currently working?**

**Y / N**

**Occupation**

**Full Duty** ☐ Light Duty

☐ **W / Restrictions**

☐ **W / O Restrictions**

➢ **Have you been placed at MMI? If so, when**

_____

**Functional activity**

*Please check and circle all that apply*

☐ **Bend**
15min. 20min. 30min. >40min.

☐ **Carry**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Climb**
15min. 20min. 30min. >40min.

☐ **Grasp**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Kneel**
15min. 20min. 30min. >40min.

☐ **Lift-floor >Waist**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Lift-waist >Overhead**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Pull**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Push**
5 lbs. 10lbs. 20lbs. 30lbs. >40lbs.

☐ **Sit**
15min. 20min. 30min. >40min.

☐ **Stand**
15min. 20min. 30min. >40min.

☐ **Walk**

List Allergies:

_____

***Physicians Notes:***

_____

_____

_____

_____

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| | | | |
|---|---|---|---|
| **What street were you on?** | | **Patient Vehicle:** | **At Fault Vehicle:** |
| **Were you wearing seatbelt?** | ☐ Yes | ☐ No | |
| **Were the police called?** | ☐ Yes | ☐ No | |
| **Were you taken to the hospital?** | ☐ Yes | ☐ No | **If so which one?** |
| **Was the car drivable or Towed from the scene?** | ☐ Yes | ☐ No | |
| **When did you start feeling pain?** | | | |
| **Do you know the estimate of the damage to your vehicle?** | | | |
| **Was there any airbag deployment?** | ☐ Yes | ☐ No | |
| **Did you visit a Primary Doctor or Chiropractor?** | ☐ Yes | ☐ No | |
| **Prior Auto Accidents** | ☐ Yes | ☐ No | **What Year? _____** |
| **Did your case Settle?** | ☐ Yes | ☐ No | |
| **Do you have residual Pain** | ☐ Yes | ☐ No | **If so, where is it located? _____** |
| **Occupational Injury History:** | | | |

## SOCIAL HISTORY

**Married ☐ Single ☐ Divorced ☐ Widowed ☐ # of Children _____**

**Do you smoke?** ☐ Yes ☐ No **If yes how many packs per day? _____**

**Do you drink?** ☐ Yes ☐ No **If Yes How much? _____ Social Drinker_____**
**Recreational Drug Use? _____**

**Family History:**

**Please Circle: Father Alive / Deceased. (If Deceased please state the cause of death) _____**

**Please Circle: Mother Alive / Deceased. (If Deceased please state the cause of death) _____**

**# of Brother____ or Sisters _____**

**Current Medication List:**

**1.** _____ **2.** _____
**3.** _____ **4.** _____

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## Medical History

| **List of Physician evaluations:** |
|---|
| |
| |
| |
| |
| **List of Treatments received and dates**: |
| |
| |
| |
| |

Please indicate which diagnostic tests you have had to evaluate the medical conditions you are experiencing today.

| | **Date** | | **Date** | | **Date** |
|---|---|---|---|---|---|
| Regular X-Ray | | C.T, Scan | | MRI | |
| Bone Scan | | Arthrogram | | Sleep Study | |
| Myelogram | | EMG/NCV | | Other | |

**Circle** the Medication that you currently take for pain

| | | | | | |
|---|---|---|---|---|---|
| Advil | Aspirin | Skelaxin | Codeine | Robaxin | Demerol |
| Dilaudid | Duragesic | Valium | Toradol | Vicodin | Fioricet |
| Flexeril | Xanax | Klonopin | Lorcet | Lortabs | Methadone |
| Tylenol #3 | Naprosyn | Neurontin | Norflex | Oxycodone | Oxycontin |
| Soma | Percocet | Ultram | Prosac | Relafen | |
| Others: | | | | | |

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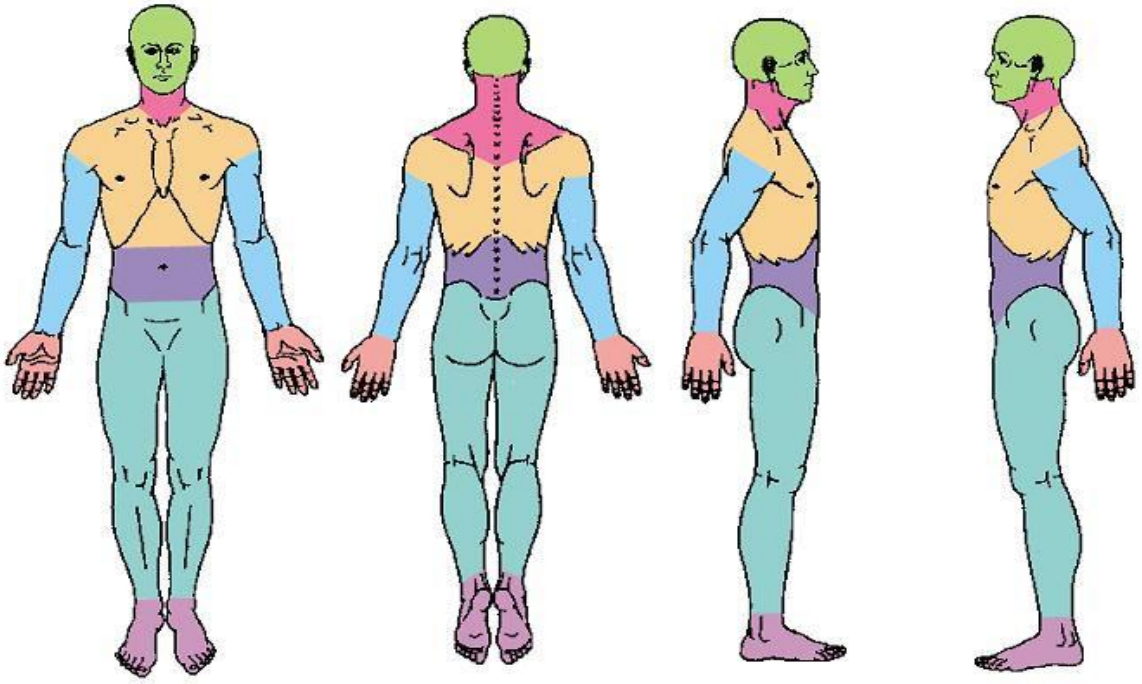
## Pain Diagram

Please **CIRCLE** the area where your pain is at

FRONT BACK RIGHT LEFT



**Please list ALL medical Conditions:**

_____

_____

_____

_____

_____

**Please list All Surgeries:**

_____

_____

_____

_____

_____

**Physician Examination (*office use only)***

_____

_____

_____

_____

_____

882 S. Kirkman Rd. Suite 305.Orlando, Florida. 32811 (407) 291-3077 Fax (407) 291-3122

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# Authorization for Release of Medical Records

I _____hereby authorize Physiatric Pain & Medical Rehabilitation Clinic to request and release all information, (including all medical reports, diagnostic reports, physical therapy notes, EMG report studies, trigger point injection records, prescriptions and patient ledgers) regarding my medical treatment and diagnosis, to the above Doctor/Attorney/ Clinic/ Hospital and/or medical facility.

□ All Imaging Reports

□ Medical Evaluation Reports

□ Physical Therapy Notes

□ Hospital Visits / Discharge Summary /History & Physical

□ Consults

□ All Medical Records

Date: ____-_____-_____

Facility Name: _____Facility Address: _____

Phone: ( ) _____ Fax: ( ) _____

Patient Name: _____Last 4 SS#_____

Address: _____

_____

Date of Birth: _____-_____-_____Valid From: _____End Date: _____

The Patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, and psychiatric treatment. To authorize release of this information, please read and sign the following:

I_____, authorize the release of alcohol and/or drug abuse treatment and information. Confidentiality is protected by FL Statute 397.053 and 396.112 and the Federal Alcohol and Drug Abuse Act. I authorize the release of HIV test results and/or HIV treatment information, and related conditions. Confidentiality is protected by FL Statute 381.609(2). I authorize the release of psychiatric information. Confidentiality is protected by FL Statute 394.459(g).

Patient Signature: _____

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## Patient Consent for Photography for Electronic Health Records

**Patient name:** _____

I consent for medical photographs to be made of me. I understand that the information may be used in my medical record.

I consent for these photographs to be used for the sole purpose of identification of medical records.

I agree to the use of my image for the purpose of medical records ***ONLY***.

## Consent for Medical Treatment

**SHARING/DISCLOSING HEALTH INFORMATION**

I authorize Physiatric Pain & Medical Rehabilitation Clinic, P.A. to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize the Practice to gain access to medical records with information relevant to my treatment from any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

**TREATMENT**

I further authorize and consent to the Practice's physicians and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, trigger point injections, epidural steroid injections (ESI's) and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

**Privacy Acknowledge Form**

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

**Patient Signature**: _____ **Date**: _____

**Witness Signature**: _____ **Date**: _____

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## RELEASE OF PATIENT INFORMATION

TO: Physiatric Pain and Medical Rehab Clinic

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to

**(Name of Person(s) whom you authorize to release records to)** **(Relationship)**

_____ _____

_____ _____

This disclosure should include:

- ☐ Office notes
- ☐ Inpatient, outpatient and emergency room treatments, Clinical charts, Reports, Treatment plans, Hospital admission records, Discharge summaries and test results.
- ☐ Laboratory records and specimens, radiology records and films.
- ☐ Prescription records and drug information related to such records.
- ☐ Billing records, including statements, insurance claim forms, and statements of benefits for the period _____ to _____.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

**Patient Signature: _____ Date: _____**

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# Assignment of Benefits

I hereby assign all rights, title, and interest from any and all automobile, health, or casualty insurance which provides medical benefits or no fault benefits to PPMRC (Assignee). I hereby authorize the insurance company to pay directly to assignee the amount of current, future bills for services rendered on my behalf and to release any requested information that is pertinent to my case to my legal representative and insurance company.

## Assignment of Cause Action

In the event my insurance company fails to pay or refusing to make timely, accurate payments to the assignee (PPMRC), I authorize the assignee (PPMRC) to prosecute said cause of action in my name or the assignees (PPMRC) name and further authorize assignee (PPMRC) to compromise, settle, and resolve said action as they see fit.

## Direction of Payment

I hereby authorize and direct you, my insurance company / my attorney to pay directly to PPMRC, P.A (assignee) such sums as maybe due and owning assignee (PPMRC) for service rendered on my behalf both by reason of accident or illness.

I also agree to pay in a current manner any differences between the total changes and the around paid by the insurance company directly to the assignee (PPMRC). I agree to pay any applicable deductible or copayment not covered by the insurance. In the event that I don't carry insurance coverage, I am fully responsible for payment for services rendered.

## PIP Log Request

I hereby authorize the assignee (PPMRC) to request a copy of the current insurance policy, declaration page, and PIP log. I hereby authorize the assignee (PPMRC) to periodically request a copy of my PIP log as they deem necessary.

## Reservation of Benefits

Please be advised that I am here by placing you on notice pursuant to Florida case law that should the insurance company / carrier deny, reduce, or fail to pay any part or an entire bill that was duly timely billed, on my behalf from PPMRC (assignee) I am requesting that you reserve, hold aside, the same amount until this dispute is resolved. Should the remaining amount of benefits approach an amount that would be deemed insufficient or an exhaustion of benefits; please notify the assignee (PPMRC) promptly.

## Severability Clause

If any term of this assignment or application thereof to any person or circumstances shall be determined to be invalid or unenforceable, the remainder of this assignment shall not be affected thereby and each term and provision of assignment, lien, and authorization shall be valid and enforced to the fullest extent of the law.

## Effective January 1, 2019

PPMRC does not accept Medicaid, Staywell, and Healthease, Amerigroup or any state funded insurance. All Medicare patients with the above mentioned secondary insurances you will be responsible for their 20% co-payment. If you have Medicare with a commercial secondary insurance, no co-payment will be collected at the time of your office visit; unless it is otherwise stated on your card.

_____
**Initial**

## Effective January 1, 2019

All copays, deductibles, and Co-insurance are due at the time of your visit. Please make sure that you have your payment at the time of your visit, or your appointment will be rescheduled.

Patients Signature: _____ Date: _____

Printed Name: _____