Physical Medicine and Rehab of Brevard, P.A.

Antonio Rivera, M.D.
F.A.A.P.M.R.

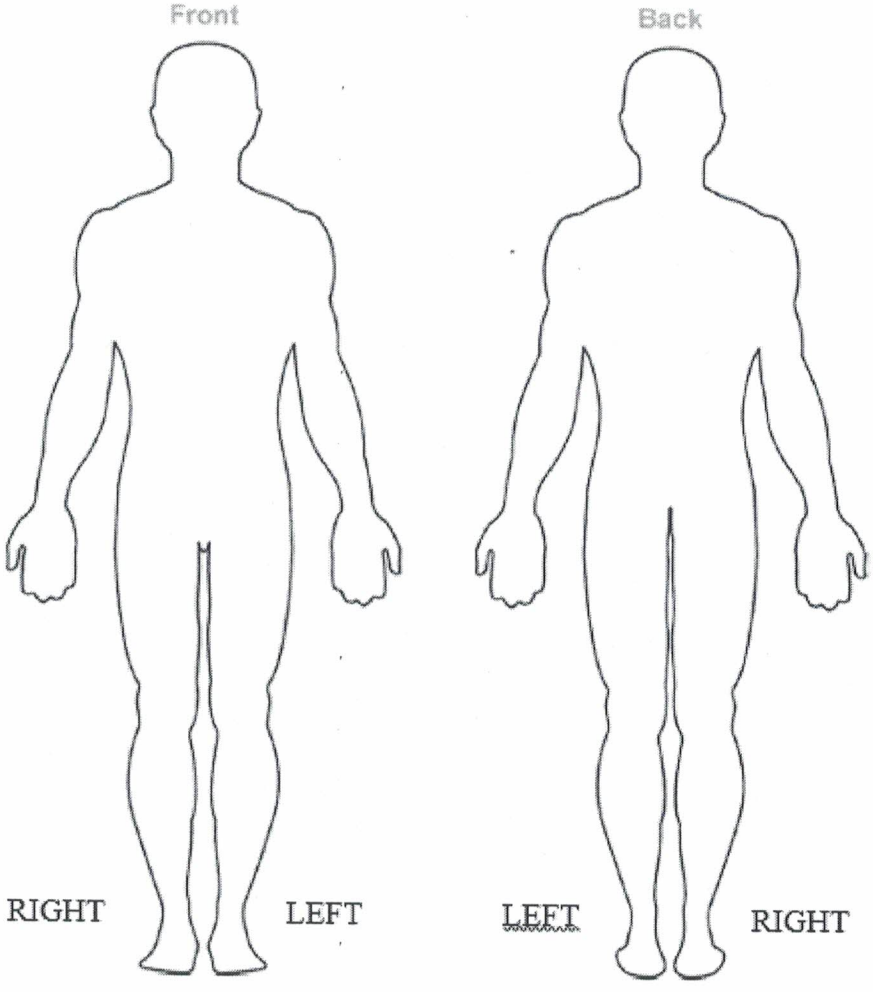
840 Executive Lane, Suite 120
Rockledge, FL 32955

Phone: 321-449-1112
Fax: 321-449-1172

PATIENT NAME: DOB:

TODAY'S DATE: _____

Please Mark Where You Are Experiencing Pain:



CIRCLE YOUR PAIN LEVEL:

No Pain — Moderate Pain — Intolerable Pain

0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN: Aching Stabbing Burning Throbbing Consistent

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ENROLLMENT FORM

PATIENT INFORMATION

FIRST NAME_____ MIDDLE INITIAL _____ LAST NAME_____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

SSN_____

DATE OF BIRTH _____/_____/_____ SEX _____

EMAIL _____

CELL PHONE_____

HOME PHONE_____

ETHNICITY: ☐ DID NOT SPECIFY ☐HISPANIC/LATINO
☐ NOT HISPANIC/LATINO

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED
☐ DIVORCED ☐ WIDOWED

RACE: ☐ DID NOT SPECIFY ☐ ASIAN
☐WHITE ☐ BLACK / AFRICAN AMERICAN
☐ AMERICAN INDIAN / ALASKA NATIVE
☐ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER

OCCUPATION_____

EMPLOYER_____

PLACE OF BIRTH_____

NEXT OF KIN_____

RELATIONSHIP_____

PREFERRED
PHARMACY & LOCATION_____

CONTACT NUMBER_____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO
IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP_____ SEX_____

FIRST NAME_____MIDDLE_____

LAST NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

CONTACT NUMBER_____

EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

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Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Physical Medicine and Rehab (hereinafter "PMR") and and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PMR of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PMR and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financially responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PMR for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PMR and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PMR, which will authorize and allow for direct payment to PMR of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PMR.

_____
Printed Name of Patient

_____
Name of Guardian/Personal Representative

_____
Signature of Patient

_____
Signature of Guardian/Personal Representative

Date: / /

Witness: _____

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INSURANCE INFORMATION **PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST**

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____ INSURED'S DOB_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

ID#_____ GROUP #_____EFFECTIVE DATE_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

Visit Summary

What medical problems (injury) brought you to the doctor today? _____

_____

When did the injury occur? _____

How did the injury occur? _____

Did the injury occur on the job? ☐Yes ☐No

What is your job description? _____

Date of Employment _____ How long in present position? _____ Date last worked? _____

☐ **Check if this is a Worker's Comp Related Injury**

Have you received treatment for this injury? _____ If yes, When? _____

Who has treated you? _____

Have you ever had an injury like this before? ☐ Yes ☐ No If yes, when? _____

Who referred you to us? ☐ Yellow Pages ☐ Insurance Co. ☐ Referring Physician ☐ Friend

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HEALTH HISTORY & INFORMATION

YES	NO	MEDICAL HISTORY	YES	NO	MEDICAL HISTORY	OTHER, PLEASE SPECIFY:
☐	☐	Stroke	☐	☐	Mental illness	
☐	☐	Heart Trouble	☐	☐	Kidney trouble	
☐	☐	High Blood Pressure	☐	☐	Cancer	
☐	☐	Diabetes	☐	☐	Bleeding Disorder	
☐	☐	Arthritis	☐	☐	Alcoholism	
☐	☐	Gout	☐	☐	Tuberculosis	
☐	☐	Arthritis	☐	☐	Lung Disease	
☐	☐	Seizures	☐	☐	Phlebitis	
☐	☐	Anemia	☐	☐	Liver Trouble	
☐	☐	Ulcers	☐	☐	Thyroid Trouble	
			☐	☐	Cause of death of any family member	

Family Health History	Disease	Who	When Diagnosed

SOCIAL HABITS: **ALCOHOL**	**CAFFEINE INTAKE**	**TOBACCO / DRUG**
Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No **If "Yes", how often?** ☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a month ☐ 4 or more times a week	☐ None ☐ 1-2 cups per day ☐ 2-3 cups per day ☐ 3-4 cups per day ☐ More than 4 cups per day	Smoke: ☐ Yes ☐ No ____ Packs per day ____ Years smoked Drug Abuse: ☐ None ☐ Presently ☐ Past Problems Tobacco: ☐ None ☐ Presently ☐ Past Problems What kind? _____ Sex: ☐ SEXUALLY ACTIVE ☐ PREGNANT OR TRYING ☐ PAINFUL INTERCOURSE ☐ CONTRACEPTIVE
Primary Care Physician: **Name:** **Phone Number:**	**Address:**	

PAST SURGICAL HISTORY / HOSPITALIZATIONS

DATE	REASON	HOSPITAL / DOCTOR

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Medications: Please list ALL prescription medications. Include ALL over the counter medications.

Name of Medication	Dosage	Dosage Schedule

Supplements: Please list ALL vitamins or prescribed supplements you are currently taking. Include ALL over the counter.

Supplements	Dosage	Dosage Schedule

Allergies:

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Additional Health History:

Yes	NO		Yes	NO		Yes	No	
		Glasses			Nausea or Vomiting			Seizures
		Change in Vision			Stomach Pain			Frequent rash
		Loss of Hearing			Ulcers			Hot or Cold Spells
		Ear pain			Frequent Belching			Recent Weight Cha
		Hoarseness			Dentures			Nervous Exhaustio
		Nosebleeds			Blood Transfusion			Trouble Sleeping
		Difficulty Swallowing			Loose Bowels			Depression
		Morning Cough			Constipation			Nervous Tension
		Shortness of Breath			Blood in Bowel Movements			WOMAN ONLY
		Chills or fever			Hemorrhoids			Irregular Periods
		Heart or Chest Pain			Frequent Urination			Vaginal Discharge
		Abnormal Heartbeat			burning on Urination			Frequent Spotting
		Badly Swollen Ankles			Difficulty Starting Urination			Taking Birth Contro
		Calf Cramps When Walking			Difficulty Stopping Urination			Could You Be Pregr
		Poor Appetite			Get Up Frequently at Night to Urinate			
		Tooth Ache			frequent Headaches			Date of Last Period
		Gum Trouble			Blackouts			_____

Immunizations:

Check off any vaccinations you have had in the past.

Tetanus(TD) _____year_____

Pneumovax(pneumonia)_____year_____

Influenza(flu shot)_____year_____

Date of your last physical exam: _____

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PATIENT RESPONSIBILITIES & AUTHORIZATIONS

PLEASE READ AND INITIAL EACH LINE.
IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST FOR ASSISTANCE.

____ I understand that my co-payment is due at each visit. Cash, check, Mastercard, and Discover cards are acceptable methods of payment.

____ I understand that I could be discharged from the practice for failing to provide notice of cancellation for three or more appointments.

____ I understand that I will be charged $25 for any returned check.

____ I understand that I am financially responsible for the charges not covered by my insurance, such as: deductibles, coinsurance.

____ I authorize the release of any medical or other information necessary to process the insurance claim(s).

____ I authorize payment directly to the billing office of this physician/clinic for the medical and/or surgical benefits, if any, otherwise payable to me for services.

____ I understand that I will be charged $25 for any/all missed appointments without 24 hour notice of cancellation prior to the appointment.

____ I understand that I may be responsible for charges related to the completion of certain forms and letters. The cost for such forms or letters is $25

____ I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account.

____ I understand that I am responsible for any collection and/or attorney fees should my account be turned over to a collection agency.

____ I authorize payment of insurance benefits to the physician or supplier for all services rendered.

I UNDERSTAND AND ACCEPT THE ABOVE RESPONSIBILITES AND AUTHORIZATIONS.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

Health Care Advance Directives

These are legal documents that communicate a person's wished about health care decisions in the event the person becomes incapable of making health care decisions. These are two basic kinds of advance directives: living wills and health care powers of attorney.

A living will express, in advance, a person's instructions or preferences about future medical treatments, particularly end-of-life care, in the event the person loses capacity to make health care decisions.

Do you have a living will? _____(Y)_____(N)

A health care power of attorney appoints a person to make decisions for the person in the event of incapacity to make health care decisions.

Also, do you have a Power of Attorney? _____(Y)_____(N)

If so, who is you POA? _____ Phone Number_____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this document is available upon request.

I understand that as part of my healthcare, Physical Medicine and Rehab of Brevard and its affiliates originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans or future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we request that you acknowledge the following information with your signature:

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail or by phone. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines.

The HIPAA Privacy rule also permits health care providers to leave a message with a family member or other person to who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present. However, covered entities should use professional judgement to assure that such disclosures are in the best interest of the individual and limit the information disclosed.

We request your acknowledgment of the above information. In doing so, we will continue to provide reminder calls, and additional information regarding appointments as a courtesy.

_____No restrictions on discussing my healthcare with family members or significant other.

Significant other: _____Phone Number:_____

I wish to be contacted in the following manner: (check all that apply)

Cell Phone:_____

_____OK to leave message with detailed information
_____OK to leave message with call-back number only

Home Telephone:_____

_____OK to leave message with detailed information
_____OK to leave message with call-back number only

Work Telephone: _____

_____OK to leave message with detailed information
_____OK to leave message with call-back number only

Written Communication:

_____*OK to fax to this number:*_____

*Patient Signature*_____ *Date:*_____

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Release of Information

Please list the names of anyone who the office staff may release information to on your behalf. If they are not on this list, no information will be released regarding your care or condition.

NAME		
RELATIONSHIP TO YOU		
CONTACT INFORMATION		
COMMENTS		

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

PRINTED NAME_____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

[__] Individual refused to accept Notice [__] Individual was unable to sign [__] An emergency prevented us from obtaining acknowledgment
[__] Individual refused to sign Acknowledgment [__] Other:

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ENROLLMENT FORM

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4.	How often have any of your close friends had a problem with alcohol or drugs?	
5.	How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6.	How often have you attended an AA or NA meeting?	0 1 2 3 4
7.	How often have you taken medication other than the way that it was prescribed ?	0 1 2 3 4
8.	How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9.	How often have your medications been lost or stolen?	0 1 2 3 4
10.	How often have others expressed concern over your use of medication?	0 1 2 3 4

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0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a need for higher doses of medication to treat your pain? **0 1 2 3 4**
12. How often have you been asked to give a urine screen for substance abuse? **0 1 2 3 4**
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? **0 1 2 3 4**
14. How often, in your lifetime, have you had legal problems or been arrested? **0 1 2 3 4**
15. How often have you felt impatient with your doctors? **0 1 2 3 4**
16. How often do you feel bored? **0 1 2 3 4**
17. How often have you rain out of pain medication early? **0 1 2 3 4**
18. How often have you counted pain pills to see how many were remaining? **0 1 2 3 4**
19. How often have others suggested that you have a drug or alcohol problem? **0 1 2 3 4**
20. How often have others told you that you have a bad temper? **0 1 2 3 4**

Please include any additional information you wish about the above answers. Thank you.

Patient Initials: _____

Staff: _____