PATIENT MEDICAL HISTORY

PATIENT NAME: _____

ARE YOU PRESENTLY WORKING?	__YES	__NO		
ARE YOU?	__RIGHT-HANDED	__LEFT-HANDED		
WHICH AREA IS THE PROBLEM?	__UPPER BACK __ARM __FINGER __FOOT __OTHER: _____	__LOWER BACK __ELBOW __HIP __TOE	__NECK __WRIST __KNEE __HEADACHES	__SHOULDER __HAND __ANKLE __TMJ
HOW DID THIS PROBLEM BEGIN?	__LIFTING __MOTOR VEHICLE	__TWISTING __UNKNOWN	__FALLING __OTHER: _____	__CRUSHING
DATE OF INJURY:	_____			
WAS THE ONSET?	__SUDDEN	__GRADUAL		
DID THE PROBLEM RECENTLY WORSEN?	__YES	__NO		
ARE YOU CURRENTLY BEING SEEN BY ANY OF THE FOLLOWING?	__MEDICAL DOCTOR __PHYSICAL THERAPIST	__SPEECH THERAPIST __OCCUPATIONAL THERAPIST	__OSTEOPATH __PSYCHIATRIST	__CHIROPRACTOR __PSYCHOLOGIST
IF YOU HAVE BEEN SEEN BY ANY OF THE ABOVE DURING THE PAST SIX MONTHS, PLEASE DESCRIBE FOR WHAT REASON:	_____ _____			
HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR THIS CONDITION?	__X-RAY	__MRI	__CAT SCAN	__BONE SCAN
PLEASE LIST ANY SURGERIES AND ANY CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:	DATE _____ _____	REASON _____ _____		

HAVE YOU EVER BEEN CLINICALLY DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?	YES	NO	YES	NO
	___	___SEIZURES	___	___CANCER
	___	___TUBERCULOSIS	___	___HEPATITIS
	___	___KIDNEY DISEASE	___	___HIGH BLOOD PRESSURE
	___	___RESPIRATORY PROBLEMS	___	___GI PROBLEMS
	___	___RHEUMATOID ARTHRITIS	___	___OTHER ARTHRITIC CONDITIONS
	___	___ELEVATED CHOLESTEROL	___	___DIABETES
	___	___DEPRESSION	___	___CHEMICAL DEPENDENCY
	___	___HEART DISEASE/HISTORY OF	___	___OTHER: _____
	___	___PACEMAKER		

DO YOU SMOKE?	__YES	__NO		
DO YOU LEAD A SEDENTARY LIFESTYLE?	__YES	__NO		
HAVE YOU EVER HAD A FRACTURE OR DISLOCATION?	__YES	__NO		
IF YES, WHICH BODY PART?	_____			
DO YOU HAVE ANY OF THE FOLLOWING METALS/PLASTICS IN YOUR BODY?	__RODS __ARTIFICIAL JOINTS	__PINS __NONE	__PLATES __OTHER: _____	__STAPLES
IF YES, WHERE?	_____			
LIST ANY CURRENT MEDICATIONS/INJECTIONS:	_____			

PATIENT SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Federal Government passed a new law in August 1996 dealing with the privacy of patient records. The new law is called Health Insurance Portability and Accountability Act, HIPAA for short. This is our general consent form.

Health Information Uses and Disclosures

In our medical practice, we routinely record, use, and disclose your health information in order to treat and to assist other healthcare providers in treating you. We also use and disclose your healthcare information in order to obtain payment for our services.

Permitted Uses and Disclosure Without your consent or Authorization

We may need to disclose your health information without your authorization in the following situations:

- To contact you by telephone or mail to remind you of appointments or to respond to your questions.
- To family members or close friends who are involved in your healthcare.
- If we are providing healthcare services to you in an emergency.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- For purposes of public health and safety, such as to the FDA to report defects or incidents
- To Government agencies for the purposes of their audits, investigations, and other oversight activities.
- For research purposes of a limited nature in a limited manner.
- For providing benefits under Worker's Compensation.
- To the law enforcement authorities to assist and or apprehend criminal offenders.
- To Government agencies for prevention of child abuse and domestic violence.
- When required by law, search warrants, subpoenas, or court orders.

Our Privacy Pledge

We have and always will respect your privacy. We will not disclose your health information without your prior written authorization, other than the uses and disclosures we describe above.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information. If they decide to contest any of your claims, your revocation authorization must be submitted to our office in writing.

Your Right to Limit Uses or Disclosures

If there are healthcare providers, hospitals, employers, or other individuals or organizations to which you do not want to disclose your information, it must be submitted in writing.

Your Patient Rights

As a patient, you have the following rights:

- To receive a copy of the Notice of Privacy Practices.
- To obtain access to and/or a copy of your health information.
- To request that we communicate with you confidentially by reasonable alternative means.
- To request how we handle or disclose your health information.
- To request amendments to your health information.
- To request an accounting of certain disclosures which we have made of your health information.

Should you have any question, concerns, or complaints regarding our Privacy Practice, now or in the future, you may contact our Privacy Official, Nicole Kelps at 561-997-2121.

You also have the right to submit a written complaint to:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201

I acknowledge that I was provided a copy of the Notice of Privacy from WitCorf for me to keep and I have had the opportunity to read and understand the notice. This acknowledgement is requested per Government Statue.

Patient Name (Please Print) _____ Parent or Authorized Representative _____

Signature _____ Date _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____

I hereby authorize WitCorf through its appropriate personnel, to perform or have performed upon me of the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I further authorize WitCorf to release to appropriate agencies, any information acquired in the course of my or the above name patient's examination and treatment.

Signature: _____ Date: _____

Relationship to Patient: ___Self ___Guardian ___Other: _____

PATIENT FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims provided verification of your insurance policies allows assigned benefits and coverage for the services rendered.

Please read the following statements carefully. By signing below you agree that you have read and fully understand all statements contained herein.

I, the undersigned, understand that WitCorf will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make payment for services rendered, I am fully responsible for all charges incurred, and will pay in full for all services. I understand that I am responsible for payment of any and all deductibles, and/or co-insurance amounts and the charges incurred are not subject to any fee schedule or reductions made by my insurance carrier. I also understand that if my treatment is due to any injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of the fess are not contingent upon settlement of a litigation; however, I hereby instruct my attorney to pay WitCorf in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting assignment means that the provider of services agrees to accept the allowable charges as determined by Medicare as full payment. However, Medicare pays 80% if the allowable charges, therefore you are responsible for the 20% balance. In addition to the 20% you are responsible for any amount applied toward your annual part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

WitCorf has explained to me that under Medicare guidelines, I will be responsible for the 20% of the allowable charge. As WitCorf has agreed to accept assignment of benefits on this portion of the charges a also, I understand that should the supplemental benefits on this portion of the charge also, I understand that should the supplemental insurance company fail to pay for these charges within a "reasonable length of time", or send payment directly to me, I will become responsible for payment in full.

WORKERS COMPENSATION COVERAGE

WitCorf agrees to treat and bill worker's compensation for preauthorized work related injuries per the Worker compensation Guidelines for the state of Florida. However, if for any reason Worker's Compensation denies liability for the treatment of the injury, I understand that I become responsible for full payment of the charges.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, hereby consent to such treatment by the authorized personnel of WitCorf as may be dictated by prudent medical practices of my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

The undersigned certifies that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I, the undersigned, authorize WitCorf to release information regarding my health care to Social Security for this or a related claim. I authorize payment from Medicare to be made directly on my behalf.

I hereby instruct and direct that _____, my Supplemental/Commercial Insurance pay by check made out and mailed to:

WITCORF, INC
1085 KANE CONCOURSE
BAY HARBOR ISLAND FL 33154

The professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment is not to exceed my indebtedness to the above-mentioned assignee and I have agreed to pay and balance of the said professional service charges over and above this insurance payment.

A PHOTOCPOY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____
Signature of Policy Holder Date

_____ _____
Signature of Claimant, if other than Policy Holder Date

_____ _____
Witness Date

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **SERVICES** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **SERVICES** below.

D. Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. **Physical therapy services two/three times per week for 4 weeks or per referring Doctor's prescription** 2. **You are enrolled in home health while receiving physical therapy services from us**	1. ***You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary.*** 2. ***Medicare will not pay for physical therapy if a patient is enrolled in a home health at the times services were performed. Home Health is to coordinate physical therapy services.***	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **SERVICES** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **SERVICES** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **SERVICES** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **SERVICES** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would** pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

MEDICARE

MEDICARE SECONDARY PAYOR SCREENING

Patient Name:_____ Patient D.O.B:_____/_____/_____

Location: _____ Date of Admission: _____

1. Was illness/injury due to a non work-related accident?
   __Yes Date of accident:_____
   __No

2. Are you receiving Black lung (BL) Benefits?
   __Yes __No

3. What type of accident caused the illness/injury?
   __Automobile
   __Non-Automobile

4. Name and address of no-fault or liability insurance:_____
   _____

   Insurance Claim Number: _____

NO-FAULT INSURANCE IS PRIMARY PAYOR ONLY FOR THOSE CLAIM RELATED TO THE ACCIDENT

5. Are the services to be paid by a research grant?
   __Yes __No

6. Has the Department of Veterans Affair (DVA) authorized and agreed to pay for care at this facility?
   __Yes __No

Patient Signature:_____ Date:_____

Verified by:_____ Date:_____

MEDICAL SOCIAL WORKER FORM

Patient Name: _____ Date: ____/____/_____

Telephone: (_____)_____-_____

Our agency is interested not only in the physical well being of our patients, but also in any problems that have arisen because of your illness/injury. Therefore, we have a Medical Social Worker available for our patients who want and need services. Please answer the questions below so that the Medical Social Worker can evaluate your situation and be of assistance if necessary. Thank you.

1. Do you wish to speak to a Medical Social Worker regarding your present situation?
   - ___ Yes
   - ___ No

   Patient Signature: _____ Date: ____/____/_____

-- IF NO, PLEASE DISREGARD THE FOLLOWING QUESTIONS --
-- IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS--

2. Type of transportation to clinic:
   - ___ Self
   - ___ Family
   - ___ Friend
   - ___ Other: _____
     Please specify

3. Are you presently employed?
   - ___ Yes Type of vocation: _____
   - ___ No Last year employed: _____

4. Does your illness/injury prevent you from making a living?
   - ___ Yes
   - ___ No

5. Do you have a spouse and/or children dependent on you?
   - ___ Yes Please specify number of dependents: _____
   - ___ No

6. Are you retired?
   - ___ Yes How long: _____
   - ___ No

7. Source of income:
   - ___ Social Security
   - ___ SSI
   - ___ Workers Comp
   - ___ VA Pension
   - ___ Pension
   - ___ Other: _____
     Please specify

8. How long have you lived in this area? _____

9. Type of residence:
   ___ Home
   ___ Apartment
   ___ Condo
   ___ Other: _____
   Please specify

10. Do you have any needs or require any information regarding community resources that may assist you in your recovery?
   ___ Yes _____
   _____
   _____
   ___ No

FOR OFFICE USE ONLY:

The above information was reviewed by a Medical Social Worker for referral or vocation services if necessary as indicated below:

___ Patient DOES NOT want social or vocational services.
___ Patient DOES need social or vocational services and has been referred or assisted as follows:
_____
_____

Signature of MSW: _____ Date: ____/____/_____