HT _____ WT _____ BP _____ PULSE _____

ADVANCED WELLNESS & ORTHOPEDICS CENTER

616 N. PALMETTO STREET
LEESBURG, FL 34748
PHONE: 352-702-0850 FAX: 352-530-2476
EMAIL: INFO@ADVANCEDWELLNESSORTHOPEDICS.COM

PATIENT INTAKE FORM FOR ORTHOPEDIC PATIENTS

NAME: _____
FIRST M.I. LAST

ADDRESS: _____
MAILING ADDRESS CITY STATE ZIP CODE

HOME PH: _____ CELL PH: _____ WORK PH: _____

DATE OF BIRTH: _____ MARITAL STATUS: (circle one) S M D OTHER

SEX: MALE _____ FEMALE _____ EMAIL: _____

HOW WOULD YOU LIKE TO BE REMINDED ABOUT YOUR APPOINTMENTS? PHONE CALL OR EMAIL

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES OR NO IF YES THEN WHO: _____

EMPLOYER / SCHOOL NAME: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE #: _____ RELATIONSHIP TO PATIENT: _____

MEDICAL INSURANCE INFORMATION:

NAME OF INSURANCE: _____ PROVIDER PH #: _____

POLICY #: _____ GROUP #: _____

NAME OF INSURED: _____ PHONE #: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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MEDICAL HISTORY

NAME: _____
FIRST MIDDLE LAST

DRUG ALLERGIES: _____

REACTION: _____

LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS YOU'RE CURRENTLY TAKING:

MEDICATION	DOSE	FREQUENCY

LATEX ALLERGY: YES or NO FOOD ALLERGIES: _____

HOSPITALIZATIONS/SURGERIES: _____

REASON/DATES (mm/yy) _____

HAVE YOU OR ANYONE IN YOUR FAMILY HAD ANY ISSUES WITH ANESTHESIA: _____

HAVE YOU EVER BEEN TREATED FOR HEPATITIS? YES or NO _____
IF YES, WHICH ONE AND WHEN: A B C DATE: _____

HAVE YOU HAD A TB TEST (TUBERCULOSIS)? YES or NO WHEN: _____
NEGATIVE or POSITIVE IF POSITIVE, DATE OF LAST CHEST X-RAY: _____

WHAT PHARMACY DO YOU USE: _____

CITY: _____ PHONE #: _____

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PLEASE CHECK ALL THAT APPLY:

- ☐ HEART MURMUR
- ☐ HEART ANGINA
- ☐ HEART ARHYTHMIAS
- ☐ HEART BURN (REFLUX/GERD)
- ☐ HIGH BLOOD PRESSURE
- ☐ ANEMIA OR BLOOD DEFICIENCY
- ☐ SWOLLEN ANKLES
- ☐ ARTHRITIS
- ☐ ULCERS/COLITIS
- ☐ URINARY/GYN PROBLEMS
- ☐ DEPRESSION AND/OR ANXIETY
- ☐ LUNG ISSUES/COUGH
- ☐ SINUS PROBLEMS
- ☐ SEASONAL ALLERGIES
- ☐ NEUROLOGICAL PROBLEMS
- ☐ SEIZURES
- ☐ PSYCHIATRIC CARE
- ☐ KIDNEY/BLADDER ISSUES
- ☐ LIVER PROBLEMS (HEPATITIS)
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM
- ☐ EYE DISORDERS/GLAUCOMA

☐ HEART DISEASE EXPLAIN: _____

☐ HEART ATTACK/STROKE WHEN: _____

☐ CANCER: WHAT TYPE? _____ YEAR: _____

☐ DIABETES - HOW LONG? _____

LAST MAMMOGRAM - DATE: _____

LAST PAP - DATE: _____

DO YOU DRINK? YES NO (CIRCLE ONE)
HOW MUCH: _____ HOW OFTEN: _____
ALCOHOL INTAKE: WINE BEER ALCOHOL
DO YOU SMOKE? IF SO, HOW MANY A DAY: _____ # OF YEARS: _____

ANY HISTORY OF ILLICIT DRUG USE (please explain): _____

_____

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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ASSIGNMENT AND AUTHORIZATION
PATIENT AGREEMENT

For good and valuable consideration, including the agreement **of Advanced Rehab Specialties, PA, d/b/a Advanced Wellness & Orthopedic Center** to accept this assignment in lieu of demanding full payment for services from the undersigned on all dates in which services are rendered. The undersigned patient executes this document hereby assigning **Advanced Wellness Center** the right to receive insurance benefits directly from any Insurance Company that is obligated to provide medical insurance benefits, either to me or on my behalf, for services rendered by **Advanced Wellness Center** due to an auto accident/injury that occurred on or around said date:_____.

All Insurance Companies obligated to pay insurance benefits to me, or on my behalf, relating to the above accident/injury for services provided by **Advanced Rehab Specialties, PA d/b/a Advanced Wellness & Orthopedic Center** are hereby directed to issue payment/s for those benefits directly to **Advanced Rehab Specialties, PA**.

I authorize and assign to **Advanced Rehab Specialties, PA** the right to file suit and pursue all legal actions to obtain payment for services rendered and provided to me by **Advanced Rehab Specialties, PA**. The authorization to file suit is an assignment of action to obtain payment for services provided to me by **Advanced Rehab Specialties, PA** and includes the assignment to pursue declaratory relief or any other legal remedies.

Advanced Rehab Specialties, PA accepts the aforesaid assignment and hereby notifies the Insurance Company issuing payment its objection to any "re-pricing", "down-coding" or "reductions" of billed amounts submitted and any such reduced payments issued are accepted under protest and without waiving any right to the provider to pursue all legal remedies and actions.

I authorize the release of any information concerning my health care or treatment provided to me to the Insurance Company to determine all benefits payable. By signing below you are stating that you fully understand this document and you agree to the terms set forth.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____ Date: _____

Authorized Signatory for Medical Provider: _____ Date: _____

Authorized Signatory Printed Name: _____ Date: _____

ADVANCED WELLNESS & ORTHOPEDICS CENTER

CONSENT FORM

(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

PLEASE INITIAL EACH PARAGRAPH

_____ I understand that as part of my healthcare Advanced Wellness Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

* A basis for planning my care and treatment
* A means of communication among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third party payer can verify that services billed were actually provided
* And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

_____ I understand and have been provided with a Notice of information Practices that provide a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

_____ With this consent, Advanced Wellness Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

_____ With this consent, Advanced Wellness Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

_____ With this consent, Advanced Wellness Center may e-mail to me appointment reminders and patient statements. I have the right to request that Commonwealth Primary Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ By signing this form, I am consenting to Advanced Wellness Center to use and disclose my PHI to carry out my TPO.

_____ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Wellness Center will decline to provide treatment to me.

PATIENT NAME: _____ **DATE:** _____

PATIIENT SIGNATURE: _____

HIPPA OMNIBUS NOTICE OF PRIVACY PRACTICES
ADVANCED REHAB SPECIALTIES, P.A.

D/B/A ADVANCED WELLNESS & ORTHOPEDICS CENTER
616 N. PALMETTO STREET
LEESBURG, FL 34748
PHONE: 352-702-0850 FAX: 352-530-2476
INFO@ADVANCEDWELLNESSCTR.COM

REGINA CURRY, RN **PHONE# 352-223-8974**

HIPPA COMPLIANCE OFFICER

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practice with respect to Protected Health Information. We are required to maintain the privacy of and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPPA COMPLIANCE OFFICER in person or by phone at the number listed above.

I have read and understand the disclosure and agree to it. I understand that I can obtain a copy at any time either electronically or printed upon request.

Print Name: _____

Signature: _____

Date: _____

Witness signature: _____

FINANCIAL POLICY

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. Co-payments. Co-payments for office visits are due at the time of service. If you are unable to make your co-payment at the time of service, Advanced Wellness Center reserves the right to reschedule your appointment until a time that you are able to make your co-payment. Payment for any outstanding balance is due at your appointment.

2. Procedure Prepayment. Advanced Wellness Center collects your payment for a n office visit at the time of the scheduled visit. Your copay is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until any previous balances or co-pays have been made.

3. Missed Appointments and Late Arrivals. If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $25 charge. Missed procedures are subject to a $58 charge. These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE PAYMENTS

4. Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Advanced Wellness Center must submit a claim on your behalf to your insurer. If Advanced Wellness Center is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the entirety of the charges.

6. Self-Pay. Advanced Wellness Center will see patients who are not insured under a letter of protection from their legal counsel in the setting of personal injury accident; If you do not fall under this category you may be seen under your health care insurance or you may pay cash for your visit. For cash visits please contact the front desk for pricing or If you have healthcare insurance and wish to be seen but are out of network, please contact the front desk for further information.

BENEFITS AND AUTHORIZATION

7. Insurance Plan Participation. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have different or higher deductibles and co-payments.

8. Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Advanced Wellness Center, it is your responsibility to be aware of this fact, and to obtain this referral.

9. Prior Authorization and Non-Covered Services. Advanced Wellness Center may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Advanced Wellness Center, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If it is determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

10. Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Advanced Wellness Center immediately.

ACCOUNT BALANCES AND PAYMENTS

11. Reassignment of Balances. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. Collection of Unpaid Accounts. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Advanced Wellness Center reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Advanced Wellness Center for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

13. Returned Checks. Returned checks will be subject to a $38 returned check fee.

14. Refunds. Refunds for overpayment or prepayment on canceled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: AWC Billing Services,

15. Statements. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of Advanced Wellness Center, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Advanced Rehab Specialists dba Advanced Wellness Center. I understand that I am financially responsible for all services I receive from Advanced Wellness Center. This financial policy is binding upon you and your estate, executors and / or administrators, if applicable.

Signed: _____

Printed Name:_____

Date: _____