Pensacola Physical Medicine, Inc.

Dr. Peter Smith, D.C.
Dr. Barbara Wade, M.D.
Lisa Della Ratta, A.R.N.P.
9007 University Pkwy. Pensacola, FL, 32514
Office: 850.476.5420 Fax: 850.476.5422

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Date of accident? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) _____ **DATE** _____

Form 2

Personal Injury Protection Coverage (PIP)
Authorization Form

Dear Patient,

You have indicated to us that you were involved in an automobile accident. As a courtesy to you, we will file for benefits under your Personal Injury Protection Coverage (PIP), so you can be reimbursed for today's services. Even if someone else is at fault, you have to use your PIP coverage for these expenses. Using your PIP coverage will not increase your auto insurance premium. Filing PIP does not relieve the "at fault" party from being responsible for payment. If the "at fault" parties insurance refuses to make payment to your insurance company on your medical bills for whatever reason, filing your PIP ensures that you are not left to pay medical bills out of your own pocket. Your insurance company gets repaid 100% by the at-fault driver's insurance.

Automobile Insurance Company Name: _____

Address: _____

Phone Number: _____

Adjuster: _____

Claim Number: _____ Policy Number: _____

Date of Accident: _____ Insured's Name: _____

I, _____ authorize Pensacola Physical Medicine, Inc. to apply for benefits on my behalf for all services rendered. I further authorize the release of all medical information necessary to process my claims. I request that payment be made directly to Pensacola Physical Medicine, Inc. and I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient or Legal Guardian Date

Pensacola Physical Medicine, Inc.

Dr. Barbara Wade, M.D. Medical Director

Dr. Peter Smith, D.C.

Lisa Della Ratta, A.R.N.P.

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Doctors Lien

Re: Reports and doctor's lien

I do hereby authorize the above doctor to furnish to you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection with the accident which I was involved.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict, by which I may eventually recover said fee.

Patient Name_____ Date of Loss _____/_____/_____

Patient Signature_____ Today's Date ____/_____/_____

The undersigned, being attorneys of record for the above mentioned patient, does hereby agree to observe all the terms of the above and agrees to withhold such from any settlement, judgment, or verdict as may be necessary to adequately protect the said doctor's name above.

Attorney's Name: _____ Phone Number_____

Attorney's Signature: _____

NOTICE: Please sign, date, and return to our office
Keep a copy for your records.
Thank You!

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. It is this provider contention its charges are reasonable based on what other doctors in the community charge and what PIP insurers have allowed for these services. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the **Office Manager**. See Fla. Stat. §673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

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 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. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
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.

The undersigned licensed medical professional 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. I have **explained** the services rendered 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 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

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

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

Licensed Medical Professional Rendering Treatment *(Signature by his or 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.

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, 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 or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We also **do not** prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of **Pensacola Physical Medicine**. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Witness (Office Staff) Date

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Patient Name_____ Date_____

Age_____ Birthdate_____ Date of last physical exam_____

What is your reason for your visit? _____

Symptoms: (Circle all that apply)

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness
Sweats

MUSCLE/ JOINT/ BONE
Pain, weakness, numbness in:
Arm
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

GENITO-URINARY
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

GASTROINTESTINAL
Appetite poor
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankle
Varicose veins

EYE, EAR, NOSE, THROAT
Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nose bleeds
Persistent cough
Ringing in ears
Sinus problems
Vision- Flashes
Vision- Halos

SKIN
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that won't heal

MEN only
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other

WOMEN only
Abnormal pap smear
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other

Date of last menstrual period:
_____
Date of last pap smear:
_____
Have you had a mammogram?
_____
Are you pregnant?
_____
Number of children: _____

Conditions:

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding disorders
Breast lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical dependency
Chicken pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart disease
Hepatitis
Hernia
Herpes
High cholesterol
HIV positive
Kidney disease
Liver disease
Measles
Migraine headaches
Miscarriage
Mononucleosis
Multiple sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate problems
Psychiatric care
Rheumatic fever
Scarlet fever
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Typhoid fever
Ulcers
Vaginal infections
Venereal disease

Medications: _____

_____

_____

_____

Pharmacy name: _____ Phone: _____

Allergies:

_____

_____

_____

_____

Patient: _____ DOB: _____ Date: _____

Family History:

Check (✓) if your blood relatives had any of the following:		
	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations:

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give approximate dates_

Serious Illness/ Injuries	Date	Outcome

Pregnancies:

Year of Birth	Sex of Birth	Complications, if any

Health Habits:

Check (✓) which substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational:

Check (✓) if your work exposes you to the following:			
	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/ her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date