

PRO SPORTS / ELITE REHAB

Please Fill This Form Out Completely

Name: _____ DOB: _____ Age: _____ Date: _____

Occupation: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Location or phone #: _____

Referring Physician: _____ Family Physician: _____

Do you have an advance directive or living will? () No () Yes If yes, who _____

History of Present Illness/Condition

Reason you are seeing the doctor today?: _____ When did symptoms start? _____

Have you been treated previously or had an X-Ray/MRI for this problem? No () Yes () Where?: _____

Past Medical History

Are you right () or left handed () Allergies to medications No () Yes () please list _____

Can you possibly be pregnant? No () Yes ()

Anemia	No () Yes ()	Lung or Breathing Problems	No () Yes ()
Arthritis	No () Yes ()	Mental Illness	No () Yes ()
Rheumatoid Arthritis	No () Yes ()	Peptic Ulcer	No () Yes ()
Asthma/Emphysema	No () Yes ()	Psoriasis	No () Yes ()
Bleeding Disorders	No () Yes ()	Pulmonary Embolus	No () Yes ()
Cancer	No () Yes ()	Seizures	No () Yes ()
Where? _____		Stroke	No () Yes ()
Diabetes	No () Yes ()	Venous Thrombosis	No () Yes ()
Gout	No () Yes ()	Pacemaker	No () Yes ()
Heart Disease	No () Yes ()	Osteoporosis	No () Yes ()
High Blood Pressure	No () Yes ()		
High Cholesterol	No () Yes ()		
HIV AIDS	No () Yes ()	Other _____	

Family History for any of the above conditions? _____ Yes _____ No relevant family history. If yes, please explain _____

Have you had any surgeries in the past? If yes, please list type and date of surgery: _____

Social History

Marital Status: S M W D Ethnicity: _____ Race: _____ Preferred Language: _____

Tobacco User Any Kind? No () Yes () If no, when did you quit?: _____

Drink Alcohol? _____ never _____ occasional _____ moderate to heavy _____ family history

Drug Overuse? _____ never _____ present _____ past problem

Reviewed with patient: _____ MD

PRO SPORTS/ELITE REHAB

Review of Systems

Patient Name: _____

D.O.B.: _____

Date: _____

Please Check Each Item "Yes" Or "No"

CONSTITUTIONAL/GENERAL

WEIGHT LOSS No () Yes ()
FEVER No () Yes ()
CHILLS No () Yes ()
NIGHT SWEATS No () Yes ()
LOSS OF APPETITE No () Yes ()
SKIN RASH No () Yes ()

EYES/VISION

VISUAL CHANGES No () Yes ()
CATARACTS No () Yes ()
GLAUCOMA No () Yes ()

EARS

HEARING LOSS No () Yes ()
PAIN No () Yes ()
RINGING No () Yes ()
DIZZINESS/VERTIGO No () Yes ()

NOSE

NOSE BLEEDS No () Yes ()
CONGESTION No () Yes ()
RUNNY NOSE No () Yes ()
INJURY No () Yes ()

THROAT

FREQ. SORE THROATS No () Yes ()
DIFFICULTY SWALLOWING No () Yes ()
HOARSENESS No () Yes ()
FOREIGN BODY No () Yes ()

HEART

HIGH BLOOD PRESSURE No () Yes ()
CHEST PAIN No () Yes ()
IRREGULAR HEART BEAT No () Yes ()
PREVIOUS HEART ATTACK No () Yes ()

LUNGS

BRONCHITIS No () Yes ()
ASTHMA/WHEEZING No () Yes ()
CONGESTION No () Yes ()

GASTROINTESTINAL

INDIGESTION/HEARTBURN No () Yes ()
ULCERS No () Yes ()
GALLBLADDER No () Yes ()
DIARRHEA No () Yes ()
DIVERTICULITIS No () Yes ()
NAUSEA/VOMITING No () Yes ()

URINARY TRACT

KIDNEY PROBLEMS No () Yes ()
PAINFUL URINATION No () Yes ()
BLOOD IN URINE No () Yes ()
PROSTATE PROBLEMS No () Yes ()

MUSCULOSKELETAL

BACK PAIN No () Yes ()
WEAKNESS No () Yes ()
ARTHRITIS No () Yes ()
JOINT SWELLING No () Yes ()
JOINT PAIN No () Yes ()
LIMITATION of MOTION No () Yes ()

NEURO/PSYCHOLOGICAL

NUMBNESS No () Yes ()
MIGRAINES No () Yes ()
SEIZURES No () Yes ()
CONVULSIONS No () Yes ()
STROKE No () Yes ()
DEPRESSION No () Yes ()

ENDOCRINE

THYROID DISORDERS No () Yes ()
DIABETES No () Yes ()
MENOPAUSE No () Yes ()
HORMONE REPLACEMENT No () Yes ()

BLOOD DISORDERS

LOW BLOOD COUNTS No () Yes ()
BLOOD CLOTS No () Yes ()
HEPATITIS No () Yes ()
HIV/AIDS No () Yes ()
OTHER No () Yes ()

Other past medical history not mentioned

Patient Signature: _____

Physician Signature: _____

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Demographics/New Problem

Patient Name: _____ Social Security # _____

Mailing Address: _____ City _____ State _____ Zip: _____

Seasonal Address: _____ City _____ State _____ Zip: _____

Home Telephone #: _____ Cellular #: _____

Email Address: _____

Employer: _____ Employer Telephone #: _____

Emergency Contact: _____ Contact #: _____

If Not Referred By a Physician, Who Referred You: _____

Issue being seen for today?:

____ Worker's Compensation ____ Auto accident ____ School athletic accident ____ Other accident ____ None

Date of Injury: ____/____/____ Problem/injury: _____

Attorney for injury? If yes name and phone number: _____

If no injury please describe your problem and date of onset: ____/____/____/_____

Any previous treatment for this problem? (X-Rays, MRI, etc.) ____ Yes ____ No If yes, what facility? _____

Insurance Information

We will need a copy of all insurance cards and a photo ID for our records.

Primary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Secondary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Financially Responsible Person (If different from above)

Name: _____ Social Security No: _____

Date of Birth: _____ Relationship to patient: _____

Mailing address if different from above: _____

City: _____ State: _____ Zip code: _____

Contact#: _____ Employer: _____

PRO SPORTS/ELITE REHAB
INSURANCE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

**Patient/Insurance Signature Authorization
Medicare and All Other Insurance**

I consent to treatment necessary for the care of the above named patient.

I authorize Peter G. Wernicki, M.D, PA., Pro Sports, Ronald Robinson, M.D., Kent Smillie, M.D., Marcus J. Malone, M.D., Worthington Keville, PA-C and Elite Rehab to appeal any claims on my behalf to my insurance company.

I authorize the release of my medical records to the referring/family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as necessary function of their role.

I request that payment of authorized Medicare benefits and/or any other insurance carrier benefits be made on my behalf to Peter G. Wernicki, M.D., PA, Pro Sports, Ronald Robinson, M.D., Kent Smillie, M.D., Marcus J. Malone, M.D., and Elite Rehab. The Medicare provider agrees to accept the Medicare assignment and the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization is to be a continued one, remaining in force until revoked in writing by the undersigned.

I acknowledge full financial responsibility for services rendered by ProSports & Elite Rehab and understand I am responsible to notify this office of any insurance changes and I have been advised that payment is due at the time of service. We do not accept any HMO plan. We are happy to submit claims for you, but ultimately the patient is responsible for payment for any charges incurred.

I understand that payment of the charges incurred, including copays, deductibles, or co-insurance is due at the time services are rendered unless prior financial arrangements have been made with our management. Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the initial \$15.00 administrative fee for balances not paid in full at the time services are rendered.

If I default on my account, I agree to pay all reasonable attorney fees, interest on account, and collections costs. The collection fees are 50% for current outstanding balances and 60% for balances greater than one year.

There will be a \$25.00 fee for all returned checks. We can file your insurance as a courtesy.

I have read and fully understand the above and I consent to treatment, financial responsibility, release of medical information, and insurance authorization.

Patient Name: _____ DOB: _____

Patient Or Parent/Guardian Signature _____ Date: _____

PRO SPORTS / ELITE REHAB
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.

ProSports & Elite Rehab are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. The terms of the privacy practices are to provide you with notice of its legal duties and privacy practices regarding your health information.

ProSports & Elite Rehab reserve the right to change our privacy practices (PHI) and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes.

ProSports & Elite Rehab may use or disclose as needed, your PHI to medical students that shadow the physicians for training. We may use a sign-in sheet at the registration desk for you to indicate your name and physician you are seeing. We may call you by name in the waiting room. We may leave a voicemail on your phone, unless otherwise notified by the patient, in case of any changes to your appointment.

I acknowledge receipt of the Pro Sports & Elite Rehab Notice of Privacy Practices. I understand that, by reading this consent form and signing, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatments, payment activities and healthcare operations.

Printed Name

ID Number or SSN

Signature

Date of Notification

You may notify me of or my listed parties below of test results, appointment reminder, and other information regarding my health information to the phone numbers provided.

_____ Message on answering machine

_____ Message on voicemail/cell phone

Below please list the people that we are allowed to release/discuss your information to:

Name (please print)

Relationship to patient

1. _____

2. _____

3. _____

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Notice of Privacy Practices

ProSports & Elite Rehab are now required by Federal Law to provide you a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review this carefully.

ProSports & Elite Rehab are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. ProSports & Elite Rehab reserves the right to change the terms of this notice of privacy and to make any new notice by requesting that all patients read and sign a new and update notice of privacy practice (PHI).

For more information about our privacy practices, or for additional copies of this notice, please contact the office manager at 772-978-7808.

ProSports & Elite Rehab may access, use or share medical information about you for treatment, payment and healthcare operations;

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. You may revoke this in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Notification to Family and Friends: We may disclose your health information to notify or assist in notifying a family member, your emergency contact or any other person to the extent to help with your healthcare or with payment for your healthcare, but only if you agree that we do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personal under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of PHI of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

Your Rights: You have the right to look at or get copies of your health information, with limited exceptions. If copies are requested, there is a charge for copies. You must make a request in writing to obtain access to your health information. You may change or add information to your health record. The request must be in writing and it must explain why the information should be amended; HOWEVER, ProSports and ProSpine may not change the original documents.

Complaints: If you need more information, have complaints or feel that your privacy rights have been violated contact: Marcus Malone, M.D., 1355 37th Street, Suite 301, Vero Beach, FL 32960. If you are not satisfied with how ProSports & Elite Rehab handle your concern, you may submit a formal complaint to: DHHS Office of Civil Rights, 200 Independence Ave SW., HHH Building, Washington, DC 20201. If you file a complaint, we will not take any action against you or change our treatment of you in anyway.