BROWARD MEDICAL & REHAB INC.
2607 Polk Street
Hollywood, Florida 33020
(954) 925-7333 Fax: (954) 925-7339

(Please Print)

Welcome to our Office

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ DOB: _____ Gender: ☐ male ☐ female

Race/ Ethnicity: _____ Preferred language: _____

E-Mail Address: _____

*How did you hear about our office: ☐ Google ☐ Zoc Doc

☐ Website (name of website) _____

☐ Friend (name) _____ ☐ Walk-in ☐ Other

_____

Referring Physician or Hospital: _____ Phone: _____

Family Physician: _____ Phone: _____

Pharmacy of Choice: _____ Pharmacy Phone: _____

(Complete this section only if someone other than the patient is financially responsible)

Responsible Party: _____ Relationship to patient: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ DOB: _____

_____ _____

(Signature of Patient or Responsible Party) (Date)

INSURANCE INFORMATION

NAME: _____ DATE: _____

PRIMARY INSURANCE

NAME OF INSURANCE CO: _____

POLICY ID NUMBER: _____

GROUP NUMBER: _____

SECONDARY INSURANCE

NAME OF INSURANCE CO: _____

POLICY ID NUMBER: _____

GROUP NUMBER: _____

ATTORNEY INFORMATION (IF APPLICABLE)

NAME OF ATTORNEY: _____

ADDRESS: _____

PHONE: (_____) _____

Did your injury happen on the job? _____ Yes _____ No

Did you report the accident to your employer? _____ Yes _____ No

Did your injury result from an auto accident? _____ Yes _____ No

If yes to any of these, please state date injury occurred. _____

Did you report the accident to your insurance company? _____ Yes _____ No

Our office will file claims for all reimbursable services to both, your Primary and Secondary insurance carriers. Please remember that you are responsible for ALL deductibles, co-pays, and non-covered services amount. See our complete financial policy for details.

Method of Payment for today's visit: CASH ____ CHECK ____ VISA/MC ____ AMEX ____

_____ _____

Signature of Patient of Responsible Party **Date**

Name: (Firma) _____ **Date: (Fecha)** _____

Age: (Anos) _____ **Height: (Altura)** _____ **Weight: (Peso)** _____

CHIEF COMPLAINT: (Queja Principal)

Why are you seeing the doctor: _____

My problem began on: _____

Type of injury: ☐ Work Accident ☐ Sports ☐ Car Accident ☐ Slip and Fall ☐ Other

Were you seen in an emergency room: ☐ Yes ☐ No

Where: _____

When: _____

PAST MEDICAL HISTORY: ☐ None

☐ Asthma ☐Colitis ☐ Bleeding Disorder ☐ Blood Clot ☐ Ulcers ☐ Diabetes ☐ Stroke ☐ Gout ☐ Fractures ☐ Arthritis ☐ High Blood Pressure ☐ Glaucoma ☐ Migraines ☐ Heart Disease ☐ Lung Disease ☐ Kidney Disease ☐ High Cholesterol ☐ Prostate Enlargement ☐ Diverticulosis ☐Hepatitis ☐ Nerve Disease ☐ HIV/ AIDS ☐ Cataracts ☐ Osteoporosis ☐ Tuberculosis

☐ Cancer (if yes, what type): _____

☐ Other: _____

PAST SURGICAL HISTORY: (Antecedentes quirurgicos pasado) ☐ None ☐ Appendectomy
☐ Hysterectomy ☐ Gall Bladder ☐ Heart Valve ☐ C-Section ☐ Breast ☐ Pacemaker ☐ Hernia
☐ Back/ Neck ☐ Skin Cancer ☐ Stomach/ Colon ☐ Prostate ☐ Heart Bypass ☐ Tonsillectomy
☐ Cataracts ☐ Hand ☐ Cancer (location) _____
☐ Joint Replacement (location) _____
☐ Arthroscopy (location) _____
☐ Other: _____
Have you ever had General Anesthesia? ☐ Yes ☐ No
Have you ever had problems with anesthesia? ☐ Yes ☐ No
If yes describe: _____

FAMILY HISTORY: Mother ☐ alive ☐ deceased Father ☐ alive ☐ deceased

SOCIAL HISTORY: __ Single __ Married __ Divorced __ Separated __ Widowed

__ Work at Home __ Student __ Unemployed __ Retired __Occupation: _____

***Smoke Cigarettes** ☐ yes ☐ no ***Drink Alcohol** ☐ yes ☐ no ***History of Substance Abuse** ☐ yes ☐ no

MEDICATION ALLERGIES: (Alergias a los medicamantos)

☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Tape

Other: _____

FOOD ALLERGIES: (Alergias a los alimentos)

_____

CURRENT MEDICATIONS: (Medicamentos acutuales) *Include Vitamins and Supplements*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

REVIEW OF SYSTEMS: (Revision de Sistemas) (Circle all that apply)

General: chills, weight loss, night sweats, fever, weight gain, appetite loss, excessive perspiration, feeling sick, fatigue.

Eyes: Double vision, halos around lights, discharge vision loss- 1 eye, blurring, eye irritation, vision loss 2 eyes, light sensitivity, eye pain.

ENT: earache, ringing in ears, ear discharge, nosebleeds, hoarseness, decreased hearing, nasal congestion, sore throat.

Cardiovascular: shortness of breath with exertion, swelling of hands or feet, leg cramps with exertion, bluish discoloration of lips or nails.

Respiratory: excessive sputum, cough, sleep disturbances due to breathing, wheezing, excessive snoring, coughing up blood.

Gastrointestinal: excessive appetite, nausea, gas, indigestion, diarrhea, vomiting, constipation, difficulty swallowing, vomiting blood, yellowish skin color, dark tarry stools, abdominal pain, change in bowel habits, bloody stools.

Musculoskeletal: muscle cramps, joint pain, stiffness, muscle weakness, joint swelling, back pain, muscle aches.

Genitourinary: painful urination, trouble starting urinary stream, pelvic pain, blood in urine, inability to empty bladder, genital sores, urinary urgency, inability to control bladder, missed periods, urinary frequency, night time urination, excessively heavy periods.

Skin: rash, itching, suspicious lesions, changes in skin color, dryness, poor wound healing, changes in nail beds.

Neurologic: headaches, falling down, tingling, poor balance, fainting, disturbances in coordination, numbness, memory loss, difficulty with concentration, tremors, weakness, sensation of room spinning.

Endocrine: heat intolerance, excessive thirst, cold intolerance, excessive hunger, excessive urination.

Home/ Lymphatic: abnormal bruising, bleeding, skin discoloration, enlarged lymph nodes.

Patient Signature: _____ Date: _____

Reviewed by: _____ D.O. Date: _____

Reviewed by: _____ D.C. Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Broward Medical and Rehab, Inc.
2607 Polk Street
Hollywood, Florida 33020
Ph.: 954-925-7333 Fax: 954-925-7339

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES & TREATMENT: I consent to treatment, diagnostic and/ or therapeutic services as ordered and/ or provided by ***Dr. Robin Simon*** or ***Dr. Bruce Mark*** as physicians of **Broward Medical and Rehab, Inc.** and their designee(s).

FINANCIAL AGREEMENT: The undersigned individually obligates him/her and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the minimum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/ or collection agency fee and expenses. The undersigned understands that **Broward Medical and Rehab** has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

ASSIGNMENT OF BENFITS: In the event that I am entitled to physician benefits of any and all types, I assign such benefits to **Broward Medical and Rehab** for services rendered to me. I authorize payment directly to **Broward Medical and Rehab** of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/ liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's Compensation and authorizes Broward Medical and Rehab to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION: I authorize **Broward Medical and Rehab** to release all or part of my medical record/ information when required or permitted by law of government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICATION: I understand that before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in **Broward Medical and Rehab**, including physician services. I authorize any holder of medical or other information about me to release to the centers of Medicare & Medicaid services or its agents any information needed to determine these benefits or benefits for related services.

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by or in **Broward Medical and Rehab** for any services furnished to me by

that physician/ supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

CONSENT FOR MEDICAL SERVICES & TREATMENT: I have been provided with a copy with a copy of the SMHCS Notice of Privacy Practices that describes how **Broward Medical and Rehab** may use and disclose my health information and also describe my rights regarding my health information.

EVALUATION OR SERVICES AND FOLLOW-UP

I give permission for **Broward Medical and Rehab**, Inc. and/ or its agent(s) to contact me for the purpose of the evaluating the services rendered to me.

YES _____ **NO** _____

The undersigned certifies that he/ she has read and understands the above, fully accepts all specified terms therein, and has received the information on patients' rights, including the mechanism for initiation, review, and resolution of complaints and copy of the SMHCS Notice of Privacy Practices.

Signature of Patient of Legally Authorized Representative: _____

Print Name of Patient or Legally Authorized Representative: _____ **Date:** _____

Signature of Guarantor of Payment: _____

Print Name of Guarantor of Payment: _____ **Date:** _____

Signature of Witness: _____

Print Name of Witness: _____ **Date:** _____

BROWARD MEDICAL & REHAB, INC.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

Name of Patient/Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip _____

AUTHORIZES MY CURRENT PHYSICIAN:

Physician Name _____

Street Address _____

City, State, Zip _____

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Physician Name/Self _____

Street Address _____

City, State, Zip _____

INFORMATION TO BE RELEASED:

I hereby authorize you to release <u>all</u> of my medical records for any treatment and laboratory/diagnostic tests performed <u>except for information pertaining to:</u>

____ Sexually transmitted disease
____ Treatment of alcohol or substance abuse
____ Records from other facilities/providers
____ Testing or treatment of HIV/AIDS
____ Communication between patient and psychotherapist for mental health treatment

For the Following Date(s): _____

PURPOSES FOR NEED OF DISCLOSURE: (check one)

____ Further Medical Care
____ Other (Specify): _____
____ Insurance/Eligibility

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand the Tenet Florida Physicians will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Tenet Florida Physicians will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so)

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six months from the date signed.

Distribution of Copies: Original to provider; copy to patient; copy to accompany released records

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient;

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI maybe disclosed to the individual(s) listed below until you notify us otherwise in writing.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

Employee signature

Date

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box which applies to you.** We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (___Sections x 10) = _____%ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Modified Oswestry Low Back Pain Disability Questionnaire

Name:_____ Date: ____/____/_____

Please Read:
This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Signature_____ Date_____

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

no pain — headache — neck — low back — worst possible pain

##########

1. **What is your pain RIGHT NOW?**

no pain _____ worst possible pain

2. **What is your TYPICAL or AVERAGE pain?**

no pain _____ worst possible pain

3. **What is your pain level AT ITS BEST?**

no pain _____ worst possible pain

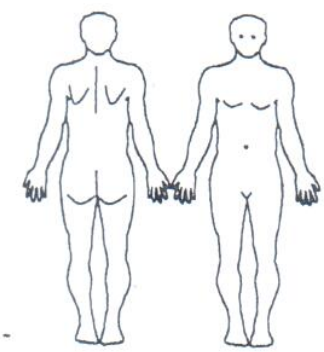
What percentage of your awake hours is your pain at its best? _____ %

4. **What is your pain level AT ITS WORST?**

no pain _____ worst possible pain

What percentage of your awake hours is your pain at its worst? _____ %

Mark the diagram as follows:
A - Ache
B - Burning
N - Numbness
P - Pins & Needles
S - Stabbing
O - Other - Describe



NAME _____ **AGE**_____ **DATE**_____ **SCORE**_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

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), 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 itemized specification of benefits and to seek §627.428 damages from the insurer. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/ unfair claims handling against my PIP insurer. 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. The undersigned directs the insurer to pay the health care provider the maximum allowable amount directly without any reductions & without the patients name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is voided, rescinded, or cancelled, 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 mail/ 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 contest and object 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 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. 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 requested to send a copy of said of said notification to this provider. 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, and 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, payout sheets, explanations of benefits 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 or billing 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 (EOB's) 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, IME's, and MRI's, 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 or potential lawsuits against the insurer in the event of non-payment. 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 are 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 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 and our privacy policies. If you do not completely understand this document please ask us to explain it to you. By signing below you acknowledge that you understand and agree to the above.

Patient's Name: _____ Patient's Signature: _____

Date: _____

BROWARD MEDICAL AND REHAB, INC.