**UPDATE FORM**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please complete each entry if there was a change in information otherwise write *‘SAME’*)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please give card and ID for file)

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please give card and ID for file)

Main Complaint/Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:

 

Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) 0-1-2-3-4-5-6-7-8-9-10 (Severe) When did your symptom(s) begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do symptoms occur? (Circle One) Occasional Intermittent Frequent Constant Is the complaint getting: (Circle One) Better Worse Same/Not Changing N/A

What activities do you find difficult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the problem(s) better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes the problem(s) worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Since we saw you last, was there a new accident/surgery/medication? If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Have you treated elsewhere? Do you have a Family Physician\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_

Do we have your permission to contact them ( Y or N) for coordination of care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***REVIEW OF SYMPTOMS*: Which of the following conditions do you now have or have you previously had?** (circle) Arthritis Asthma Sinus Issues Blood Clotts Allergies Tuberculosis Diabetes Vertigo ADD/ADHD Epilepsy Migraine/HA’s Thyroid High BP Low BP Heart Trouble Pacemaker HIV/AIDS Cancer Polio Scoliosis Mental/Emotional Prostate Trouble Hormonal Dislocation Disc Herniation/Bulge Rheumatic Fever Bone Fracture Osteoporosis Kidney Disease Digestive Trouble Acid Reflux Sleep Disorder

***Family History, any new information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Receipt of Notice of Privacy Practices Written Acknowledgement Form**

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below **(ex. a family member, lawyer, or another health provider office who may request your records or need to discuss care – please list name and/or organization below on the line provided)**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, assign all of the rights and benefits of any

applicable health insurance policies, personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Erika Meister DC at Blue Q Health and Wellness PLLC or other provider, for services and supplies provided to me.

I agree to pay any co-payment or deductible not covered by the applicable health insurance policy, personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

* all rights to collect benefits directly from any insurance carrier obligated to provide
* benefits for services and supplies I have received;
* all rights to take legal or other action against any insurance carrier obligated to provide
* benefits if for any reason the insurance carrier fails to pay any benefits due; and
* all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees
* and costs, for any legal or other action taken by Blue Q Health and Wellness PLLC as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I agree that Blue Q Health and Wellness PLLC or health provider may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries. I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (or Guardian) Date

The undersigned, as authorized representative of Blue Q Health and Wellness PLLC accepts the assignment of benefits as set forth above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative of Blue Q Health and Wellness Date