Welcome to Bretz Rehabilitation Clinic

We are a multi-disciplinary practice that *specializes* in the care of injury victims. Our Chiropractors, Medical Doctors, Nurses/CMA's and Massage Therapists unite in rehabilitating our patients to maximum medical improvement. We will anticipate our patients' needs and we are committed to providing a wide variety of treatment to benefit all types of injuries. You have taken the first step in your rehabilitation by choosing our practice to tend to your needs. Each patient is equally important to us so in an attempt to form a long-term relationship with you, here are a few things that will help guide you through your treatment.

Patient Advocate- Steven LeBlanc 941-921-2225

This is your patient advocate and attorney liaison. He is available to answer all of your questions in regard to your care. Many patients find it necessary to seek legal representation and with much experience in this field, Steven has the resources to provide you with many choices.

SIGNING IN

When you arrive, sign in. You will be called back in the order of your appointment time. Other patients being treated by another doctor may be called before you because their doctor is available, not because they are taken out of turn.

HOURS

The office and doctors have specific office hours. The Medical office staff will schedule your appointments accordingly. If you have a special request for an appointment time, speak with the office staff and we will accommodate your needs if possible.

MISSING OR CHANGING APPOINTMENTS

Each patient is evaluated and given a specific course of treatment that will most benefit your injuries. A certain number of treatments are required in a specific amount of time for us to get the results we both desire. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week. Please be responsible and call our staff if you cannot make an appointment or you are going to be late for your appointment. If you are late for an appointment and have not called, you may be asked to wait until we have an opening.

OFFICE POLICY

Regardless of who the responsible party is, a claim will be established with your insurance company by Florida Law. Contact your agent and inform them of your care in this office and have all forms sent directly to us. It is your responsibility to supply us with the coverage information of the vehicle you were in at the time of the accident. If you are making a claim against the liability policy of another vehicle and an attorney represents you. We will send a copy of the bills and records to your attorney.

You are personally responsible for the bill, but you will not be required to pay at the time of service as long as we are billing your insurance company and/or attorney and the necessary lien forms have been signed by you, ensuring that we will be paid at the time of the settlement of your case. This is done as a convenience to you.

DRUG POLICY

*Any medications prescribed by the doctor today are to be taken as prescribed. We are **UNABLE** to refill prescriptions sooner than the **appropriate date**.

*If a prescription is prescribed to you by one of our doctors and you find that it is not working, you **MAY** be asked to bring in the **UNUSED PORTION** of the medication into our office before a different medication is prescribed to you. Without this, a new medication **MAY NOT** be prescribed.

*If your prescription is stolen and a new prescription is requested from one of our doctors, you **MUST** present to our office a copy of a police report **BEFORE** we are able to issue a new prescription. Without the report, our office **WILL NOT** write a script until the appropriate date.

*No medication (new or refill) can be given at night or on weekends. Medication can only be ordered by your doctor during regular business hours when your chart can be accessed.

*If in the event you are referred to Pain Management, prescriptions will **NO LONGER** be given by our office. They **MUST** be obtained from the Pain Management office.

Bretz Rehabilitation Clinic
Patient Intake Form

Treating Office: ___ St. Pete ___ Sarasota

Patient Name: _____ Soc Sec #: _____

Office use only
___MVA ___S/F ___W/C ___PI ___Other / Driver ___ Passenger___ Pedestrian___
___Motorcycle ___Bicycle If passenger, did the vehicle belong to: Patient___ Other ___
Date: ___/___/___ Date of **injury**: ___/___/___ Was accident work related: Yes__No__

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell phone: _____

E-mail address: _____

Age: _____ Date of Birth: ___/___/___ Sex: M___ F ___

State accident occurred:_____ Marital Status: M S D W

Are you currently under a doctor's care for this injury? Yes ___ No ___

If yes, please list facility / Doctor and phone number:

_____

_____

_____

Did you have **X-rays**? Yes___ No ___ **MRI's**? Yes___ No ___ **CT's**? Yes___ No ___

Primary care physician: _____ Phone: _____

Attorney Name: _____ Phone: _____

Attorney Address: _____

City: _____ State: _____ Zip: _____

Please have your driver's license, Auto Insurance card, Health Insurance Card and Accident Report available for copy. Thank You.

Office use only
LOP requested: Yes ___ No ___ , Date: _____ Received: _____
AOB Sent: Yes ___ No ___, Date: _____

Letter of intent to bill sent: Yes ___ No ___ , Date: _____ Received: _____ Page 2

Updated 2/21/2018

Past medical history:
Patient Name:_____

Do you have or have you been treated for any of the following: circle yes or no

fibromyalgia	Y/N	heart disease	Y/N	high blood pressure	Y/N	gastritis/ulcers	Y/N
asthma	Y/N	stroke	Y/N	osteoporosis	Y/N	low/high thyroid	Y/N
liver disease	Y/N	depression	Y/N	immunodeficiency	Y/N	kidney disease	Y/N
diabetes	Y/N	seizures	Y/N	bleeding disorder	Y/N	cataracts	Y/N
cancer (type)_____	Y/N			hepatitis (type) _____	Y/N	glaucoma	Y/N
HIV/AIDS (precautionary measures)	Y/N			contagious skin disorder	Y/N		

please list any health problems not listed above:_____

Hospitalization (include this accident)/operations/previous auto accidents:

Date	Incident(Auto Accident or S/F)	Reason/procedures	Hospital

Current medication (please include any vitamins or herbal medications):

Name	Dose	Frequency

Medication allergies:
List any medication allergies and the type of reaction:(if none are known check here__):

_____

Family history: please check all that apply to your family members (M/mother, F/father):

Allergy	___M ___F N/A___	high blood pressure	___M ___F N/A___
Osteoporosis	___M ___F N/A___	kidney disease	___M ___F N/A___
Seizures	___M ___F N/A___	stroke	___M ___F N/A___
Cancer	___M ___F N/A___	depression	___M ___F N/A___
Diabetes	___M ___F N/A___	other	___M ___F N/A___
heart disease	___M ___F N/A___		

Social history

1. do you presently smoke? Y/N #packs/day___ #years___
2. have you ever smoked? Y/N #packs/day___ #years___
3. do you drink alcohol? Y/N #drinks/day___
4. have you ever used any addictive substances? Yes___(substance:_____) no___

Review of systems: please circle yes or no. If yes, please explain:

1. Ears: ringing/dizziness/drainage/hearing loss Y/N explain:_____
2. mouth/throat: pain or difficulty swallowing/hoarseness/lumps in neck Y/N explain:_____
3. cardiopulmonary: chest pain/palpitations/short of breath/heart murmur/cough Y/N explain:_____
4. genitourinary: burning or frequency of urination Y/N explain:_____
5. gastrointestinal: heartburn/vomiting/diarrhea/abdominal pain Y/N explain:_____
6. psychological: depression Y/N explain:_____
7. sleep pattern: snoring/daytime sleepiness Y/N explain:_____
8. endocrine: heat intolerance/cold intolerance/excessive thirst Y/N explain:_____
9. eyes: recent changes in vision/impaired vision/double vision Y/N explain:_____
10. neurologic: weakness/numbness Y/N explain:_____
11. musculoskeletal: TMJ disorder/arthritis Y/N explain:_____
12. Gen.: nausea/fever/fatigue/weight gain Y/N explain:_____
13. skin: skin cancer Y/N explain:_____
14. hematologic/lymphatic: swollen lymph nodes Y/N explain:_____
15. immunologic: hepatitis/frequent infections/immune disorders Y/N explain:_____
16. Constitution: sudden weight loss or gain? Y/N explain:_____
17. are you pregnant? Yes___ no___how many months?___
18. Are you breast-feeding? Yes___ no___

Patient Signature:_____

Patient history checklist:

Office: Sarasota___ St. Petersburg___
Patient Name:_____ Date:_____
height:___ weight:___ age:___
Left or right handed: left___ right___ Date of Accident:_____
Vehicle information: car___ truck___ motorcycle___ SUV___ bus___ bike___
Where was a vehicle hit from? Front___ rear___ right side___ left side___
Were you the? Driver___ passenger___ pedestrian___ bike___ motorcycle___
Were seatbelt restraints used? Yes___ no___

Please answer the following questions as it relates to your condition after the accident: circle yes or no and explain if yes.

Head:

1. do you recall hitting your head during impact? Y/N explain:_____
2. do you have headaches? Y/N explain:_____
3. what areas do you feel the headache? _____
4. were you dazed? Y/N explain:_____
5. did you lose consciousness? Y/N explain:_____
6. what is the first thing you remember after impact? _____
7. did you see a bright flash of light? Y/N explain:_____
8. have you seen? Floating spots: Y/N explain:_____
   sparkling dots: Y/N explain:_____
9. any dizziness? Y/N explain:_____
10. any blurry vision? Y/N explain:_____
11. any nausea/vomiting? Y/N explain:_____
12. do you notice a head rest/lightheadedness when standing up? Y/N explain:_____
13. does your head or face have? Numbness? Y/N explain:_____
    tingling? Y/N explain:_____
    stinging? Y/N explain:_____
14. any ringing in your ears? Y/N explain:_____
15. when you open your jaw do you have? Clicking? Y/N explain:_____
    Popping? Y/N explain:_____

Cranial nerves:

1. when you have headaches do you have pain behind your eyes? Y/N explain:_____
2. when you have headaches T of sensitivity to light? Y/N explain:_____
3. any loss of normal vision? Y/N explain:_____
4. any loss of ability to move both eyes without a problem? Y/N explain:_____
5. any problem winking eyes are closing them? Y/N explain:_____
6. any loss of ability to taste? Y/N trouble moving your tongue? Y/N explain:_____
7. any loss of ability to hear? Y/N explain:_____
8. any difficulty/pain swallowing? Y/N explain:_____
9. any hoarseness in your voice? Y/N explain:_____
10. any trouble shrugging your shoulders? Right/left? Y/N explain:_____
11. any trouble smiling? Y/N explain:_____

Medical history since the accident:

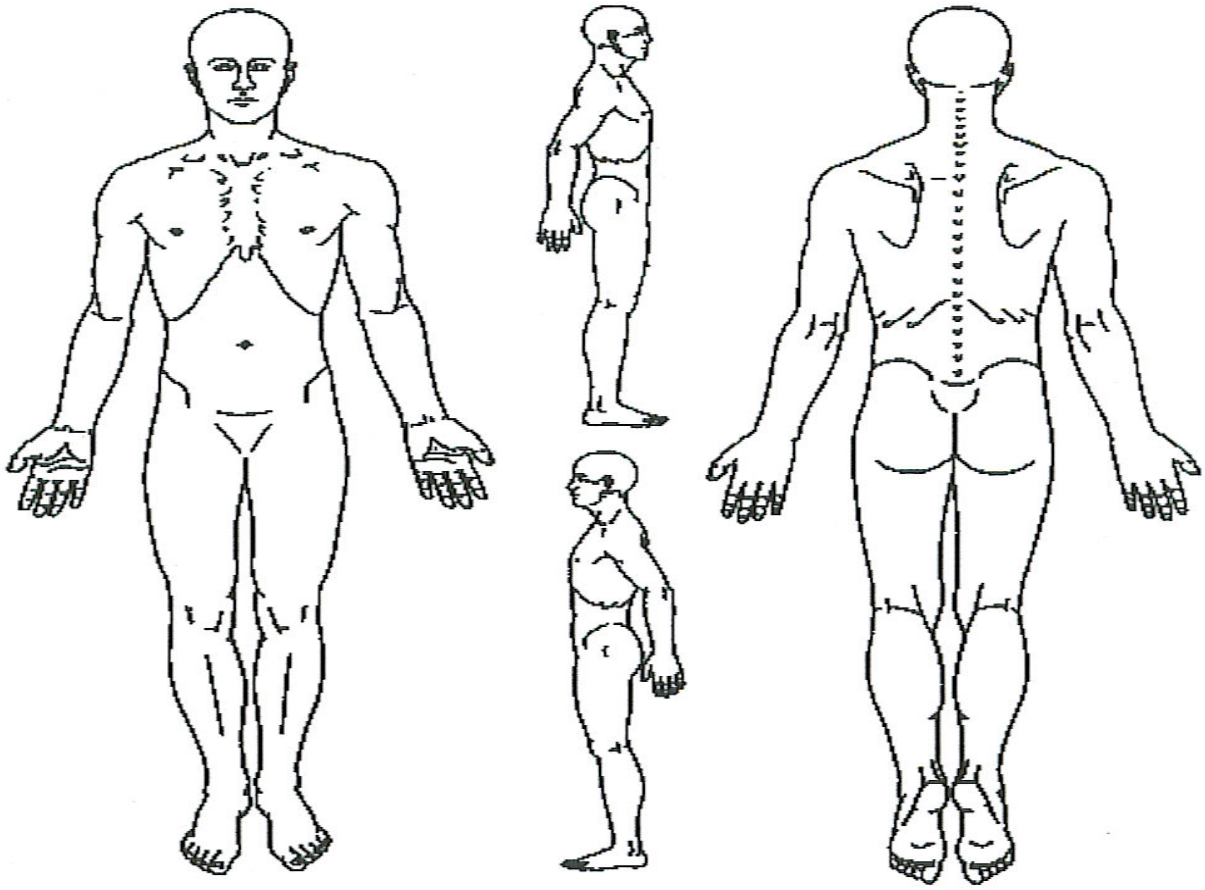
1. difficulty sleeping due to pain? Y/N explain:_____
2. trouble with memory? Y/N explain:_____
3. mood swings since accident? Y/N explain:_____
4. feel depressed? Y/N explain:_____
5. feel tired or fatigued? Y/N explain:_____
6. any sexual problems? Y/N explain:_____
7. are you employed, retired, disabled, student or minor?_____
8. are you out of work due to this accident? Y/N how long? ___
9. What type of work do you do?_____ (computer, long sitting, standing, bending, etc.)

Patient Signature:_____ Dr. Initials_____

PAIN DIAGRAM

NAME _____ DATE _____

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

-

I certify that I have read and understand all the information requested of me concerning my medical history and health problems, and that my answers are true and accurate to the best of my knowledge. I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment, and/or advice necessary.

Date:_____ Patient Name:_____

Patient Signature:_____

Attending Doctor: I have personally reviewed the history and review of systems:

Date:_____ Dr. Signature:_____

Bretz Rehabilitation Clinic

5989 Approach Rd.
Sarasota, Fl
(941) 921-2225 Fax (941) 927-8234

Treating Office: Sarasota ____ St Pete ____

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOI: _____ Claim #_____
Insurance Carrier: _____ Policy # _____

ASSIGNMENT OF BENEFITS/POLICY RIGHTS/DIRECT PAYMENT AUTHORIZATION

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Bretz Rehabilitation Clinic ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient for its failure to pay for services rendered unto me by assignee in relation to any accident or illness. This assignment may only be rescinded/reassigned by the mutual consent of the patient/insured/assignor and health care provider/assignee.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of any benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

DIRECTION OF PAYMENT/RELEASE OF INFORMATION

I hereby authorize any insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of Insurance or declaration sheet, to be provided by the insurance company to the Assignee. I hereby authorize Assignee permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

_____ _____
Patient's signature or patient/guardian Date

Application For Benefits – Personal Injury Protection

(To enable us to determine if you are entitled to benefits under the personal injury protection law, please complete this form.)

Date_____Our Policy Holder_____DOI_____CL#_____

Policy Holder Name_____Policyholder DOB_____Home#_____

Policyholder Address_____Bus.#_____

Date and Time of Acc._____Place of Acc._____SS#_____
Brief Description of Acc.

At time of Accident: Were you the driver of the policyholder's car? Yes__ No__ Were you the passenger in the policyholder's car? Yes__ No__ Were you a pedestrian? Yes__ No__

Are you a member of our policyholder's household's household? Yes__ No__ Relationship to policyholder_____
As a result of the accident, were you injured? Yes__ No__ If your answer is yes, please complete the rest of this form. If No, Sign here and return the form to us.
Signature:

Describe your injury:

Were you treated by a doctor: Yes__ No__ Date of first treatment_____If you were treated in the hospital: Inpatient___ Outpatient___
Doctor's name and address:

Hospitals name and address:

Amount of bills to date_____ Will you have more medical expenses? Yes__ No__ Were you employed at time of accident? Yes__ No__
Did you lose time from work? Yes__ No__ If yes. Amount lost: $_____Average weekly wage or salary:$_____
If you lost time: Date disability began___/___/___ Date you returned to work___/___/___

Have you received or are you eligible for benefits under:
1) Workman's Compensation Law? Yes__ No__ If yes, amount: $_____
2) Employment by U.S. Government? Yes__ No__ ___ per week ___ per month
3) Military? Yes__ No__

List name and addresses of your employers at the date of the accident and give occupation and dates of employment

Employer address_____Occupation _____From _____ To_____

Employer address_____Occupation _____From _____ To_____

Any person filing a statement of claim containing any false, incomplete of misleading information is guilty of a felony of the third degree. I declare that the facts shown hereon are true and complete to the best of my knowledge and that no attempt has been made to conceal facts or to deceive any insurance company.

Signature_____ Date _____/_____/_____

Bretz Rehabilitation Clinic

5989 Approach Rd.
Sarasota, Fl.
(727) 321-6130 Fax (727) 317-4945

Patient Name: _____

Authorization to obtain PIP Payouts / Payment EOB's

Request under section S.627.736(7)

Policy# _____

Claim# _____

I, _____ authorize my PIP Insurance carrier to immediately provide a PIP Payout explanation to **Bretz Rehabilitation Clinic.** I also authorize an Explanation Of Benefits (EOB) be included with each payment to this physician's office.

_____
Patient's signature

_____
Date

Patient's Assignment of Benefits is attached

Bretz Rehabilitation Clinic

5989 Approach Rd.
Sarasota, FL.
(727) 321-6130 Fax (727) 317-4945

Office: Sarasota ___ St Pete ___

Patient Name: _____

IRREVOCABLE DOCTOR'S LIEN

Attorney Name & Address: _____
_____
_____

I do hereby authorize Bretz Rehabilitation Clinic to furnish you, my attorney with a full report of my case history, examination, diagnosis, treatment, and prognosis in regard to my accident/illness which occurred/began on _____.

I hereby authorize and irrevocably direct you my attorney, to pay directly to Bretz Rehabilitation Clinic, sums due and owed for professional services rendered both by reason of this accident and any other bills that are due this office and to be necessary adequately to protect Bretz Rehabilitation Clinic. I hereby further give a 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 therewith.

I fully understand that I am directly and fully responsible to Bretz Rehabilitation Clinic. for all professional bills, submitted by them for services rendered me, and that this agreement is made solely for said facility's additional protection and in consideration of payment. I further understand that such payment is not contingent on any recover said fee.

_____ _____
Patient/client signature Date

I have been advised that if my attorney does not cooperate, Bretz Rehabilitation Clinic. will not await payment, but may declare the entire balance due and payable.

The undersigned being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from settlement, judgment, or verdict as may be necessary to protect adequately Bretz Rehabilitation Clinic.

_____ _____
Attorney's signature Date

Bretz Rehabilitation Clinic

5989 Approach Rd.
Sarasota, FL.
(727) 321-6130 Fax (727) 317-4945

Patient Name: _____

Benefit Assignment to Patient

I, _____ am seeking medical treatment for injuries sustained in a motor vehicle accident on, _____ / _____ / _____.

I **do not** have PIP insurance of my own. Mr. / Ms. _____ has motor vehicle insurance with _____, Policy #_____, Claim#_____, which I meet the state required qualifications, S.627.733 to be covered by this policy.

_____ _____
Patient's signature Date

I, _____, the policy holder, do authorize the above named person to use my vehicle insurance for filing medical claims for the above mentioned motor vehicle accident, Policy# _____,
Claim# _____.

_____ _____
Policy Holder's signature Date

Explanation of Financial Responsibility, according to Florida PIP Laws

1) If you have a policy with a deductible:

You, the patient, are responsible to pay your deductible.

Should you have an attorney to represent you with your case the deductible share will be part of the settlement at the end of your case, providing your lawyer issues us a Letter of Protection.

2) If you have chosen a policy that pays a percentage of the medical charges:

You, the patient, are responsible to pay the percentage not paid by your insurance.

Should you have an attorney to represent you with your case the percentage share will be part of the settlement at the end of your case.

3) Should you not be represented by an attorney and are faced with financial hardship please notify a staff member.

I have read and understand the above information

_____ _____

Patient's signature **Date**

Bretz Rehabilitation Clinic
5989 Approach Road
Sarasota, FL 34238
941-921-2225 Fax 941-927-8234

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
  [ ] Please check here if you do not want us to leave a message on your mobile voice mail.

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____
  _____

- You may request a copy of, or as a new patient, will be given a copy of our "*Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.

- You have read or have had the right to read the "*Notice of Patient Privacy Practices"* prior to signing this authorization.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name: _____ DOB_____ SS#_____

_____ _____ _____
Signature Print name of person signing Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____