PrimaCare EMC, INC

* CONFIDENTIAL PATIENT CASE HISTORY *

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time to answer each question as completely as possible and please sign each page.

TODAYS DATE: _____ DATE OF ACCIDENT: _____

Patient Information -

First Name: _____ Middle Initial: _____

Last Name: _____ Gender: _____ Race: _____

DOB: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Work Phone: _____

Marital Status: _____ Email Address: _____

Insurance Information -

Auto Insurance: _____

Name of Insured: _____

Policy#: _____

Group#: _____

Claim#_____

Attorney Information -

Name of Attorney: _____

Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Please be advised that I have been consulted by and have been rendering medical treatment to the above referenced patient, with the patient's first day of treatment occurring on _____.

Enclosed, please find a direction to pay, which the patient has directed you to send all payments for services rendered to the undersigned. The patient has also granted us a lien on the benefits.

In accordance with F.S.627.736(5)(b), I will timely be submitting the bills.

_____ _X_____

Authorized Representative **Patient Signature**

PrimaCare EMC, INC

Accident Information -

What is the cause of your pain or condition?

☐Motor Vehicle Accident ☐ Motorcycle Accident

Were you? ☐Driver ☐Passenger ☐Front seat ☐Rear seat

Was the vehicle? ☐Stopped ☐Moving Did you hit another vehicle/object? ☐Yes ☐No

Were you wearing a seat belt? ☐Yes ☐ No

What part of the vehicle was hit? ___________________________

Did you go to the hospital? ☐ Yes ☐No

If yes, which hospital? ________________________________

Were you admitted? ☐Yes ☐ No

Discharge Date: __________________________

First date you sought treatment: _________________

Are you getting therapy? ☐Yes ☐No

How often? ______________________

Are you able to work? ☐Yes ☐No

Are you able to sleep? ☐ Yes ☐No

Is there any other information that is important for your condition?

____

____

Current Health Information -

Tobacco Use? ☐Yes ☐No ☐Former Smoker

Alcohol Use? ☐ Yes ☐No

Any allergies to medications? ☐Yes ☐No

If yes, please list: ______________________________________

Please list any current medications that you are taking and their strengths:

(Include any over the counter medications such as ibuprofen, tylenol, etc.)

____

____

Patient Signature: ____ Date: ____________________

PrimaCare EMC, INC
3236 Dr. Martin Luther King Jr. Street N. - St. Petersburg, FL 33704
Phone: (727) 823-4848 Fax: (727) 823-4880

Authorization for Medical Information

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law. (Chapter 71-252 F.S.)

Consent For Treatment

I hereby authorize your practice and whomever the health care professionals may designate as their assistant to perform examinations, physiotherapy, physical therapy, and perform noninvasive diagnostic tests. If any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating health care professional deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

Release of Records

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage. This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays, physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law. (Chapter 71-252 F.S.)

Acknowledgement of Receipt of Notice Privacy Practices

I have been presented with a copy of the notice of privacy practices detailing how my health information may used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Payment Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that PrimaCare Health, LLC will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly to PrimaCare Health, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below I agree to all above statements.

Patient Signature: _____

Date: _____

PrimaCare EMC, INC
3236 Dr. Martin Luther King Jr. Street N. - St. Petersburg, FL 33704
Phone: (727) 823-4848 Fax: (727) 823-4880

Assignment of Benefits

I hereby assign form any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title, and interest to PRIMACARE HEALTH, LLC ("Assignee") for payment for services rendered unto me both by 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 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 my accident or illness. This assignment may only be rescinded/reassigned by the mutual consent for the patient/insured/assignor and the 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 my 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, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the Assignee. I hereby authorize Assignee the 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.

By signing below I agree to all above statements.

Patient Signature: _____

Date: _____

PrimaCare EMC, Inc.

ASSIGNMENT OF BENEFITS,LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

For and in consideration of PrimaCare EMC, Inc. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to PrimaCare EMC, Inc. for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize PrimaCare EMC, Inc. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to PrimaCare EMC, Inc. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by PrimaCare EMC, Inc. as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with PrimaCare EMC, Inc. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to PrimaCare EMC, Inc. including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for PrimaCare EMC, Inc. and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, PrimaCare EMC, Inc. will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to PrimaCare EMC, Inc. at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to PrimaCare EMC, Inc. at the address on the bill. PrimaCare EMC, Inc.'s medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is cither reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by PrimaCare EMC, Inc. I further instruct my insurance company to make payment for charges submitted by PrimaCare EMC, Inc. in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give PrimaCare EMC, Inc. limited power of attorney to endorse and sign my name on any draft for payment to either PrimaCare EMC, Inc. or myself if said draft represents payment for charges related to services rendered by PrimaCare EMC, Inc.

I further direct my insurance carrier or responsible other entity to provide information to PrimaCare EMC, Inc. which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of PrimaCare EMC, Inc. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Patient Name	Date

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

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 or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Initial Consultation

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.

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.

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

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date
John L. Wheeler, ARNP		

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.

PRIMACARE EMC
3236 Dr. MLK Jr. St. N.
St. Petersburg, FL 33704
PH: 727-823-4848 FX: 727-823-4880

Patient Name: _____ Date:_____

OFFICE VISITS: ___ 99205 HIGH COMPLEXITY ___99204 MODERATE COMPLEXITY ___97535 HOME MANAGEMENT TRAINING

DIAGNOSIS

__M53.82 Cervical Spine Disorder
__M54.2 Cervicalgia
__M54.12 Cervical Radiculopathy
__M50.90 Cervical Disc Disorder
__M50.00 Cervical Disc Disorder w/ Myelopathy
__M50.10 Cervical Disc Disorder w/ Radiculopathy
__S13.4XXA Cervical Sprain/Strain
__M43.6 Torticollis
__M50.30 Cervical Disc Tear
__S13.4XXS Cervical Vertigo
__M99.19 Subluxation of Antlanto-Occipital Joint
__M99.01 Cervicothoracic Segmental Dysfunction
__M48.8X9 Retrolisthesis
__M50.20 Cervical Herniation

__M53.9 Thoracic Spine Disorder
__M54.6 Thoracic Pain
__M51.14 Thoracic Disc Prolapse w/ Radiculopathy
__M51.9 Disc Disorder of Thoracic Spine
__S23.3XXA Thoracic Sprain/Strain
__M51.24 Thoracic Herniation
__M99.02 Thoracic Segmental Dysfunction
__S24.2XXA Thoracic Nerve Injury
__M51.34 Thoracic Disc Tear

__M53.9 Lumbar Spine Disorder
__M54.5 Acute Lower Back Pain
__M54.40 Lumbago w/ Sciatica
__M54.42 Lt Sided Lumbago w/ Sciatica
__M54.41 Rt Sided Lumbago w/ Sciatica
__M54.16 Lumbar Radiculopathy
__M51.16 Lumbar Disc Prolapsew/ Radiculopathy
__M51.9 Lumbar Disc Disorder
__M51.06 Lumbar Disc Disorder w/ Myelopathy
__S33.9XXA Lumbar Sprain/Strain
__M51.26 Lumbar Herniation
__M51.36 Lumbar Disc Tear
__M40.40 Acquired Lordosis
__M40.30 Flattened Lordosis
__S34.21XA Lumbar Nerve Injury
__M99.03 Lumbar Segmental Dysfunction
__M54.32 Lt Sided Piriformis Syndrome
__M54.31 Rt Sided Piriformis Syndrome
__M53.3 Coccyx Pain

__M25.519 Shoulder Pain
__M25.619 Shoulder Stiffness
__M75.00 Shoulder Adhesive Capsulitis
__S43.90XA Shoulder Sprain/Strain
__S46.812A Trapezius Strain
__S46.019A Supraspinatus/Infraspinatus Strain
__M75.80 Infraspinatus Tendonitis
__M75.92 Lt Shoulder Tendonitis
__M75.91 Rt Shoulder Tendonitis
__M65.819 Shoulder Synovitis/Tenosynovitis
__M67.412 Lt Shoulder Ganglion
__M67.411 Rt Shoulder Ganglion
__M75.110 Supraspinatus Tear
__M19.112 Lt Rotator Cuff Tear w/ Arthropathy
__M19.111 Rt Rotator Cuff Tear w/ Arthropathy
__M75.100 Rotator Cuff Partial Thickness Tear
__S46.001 Rt Rotator Cuff Tendon Injury
__S46.002 Lt Rotator Cuff Tendon Injury
__M75.50 Shoulder Bursitis
__M25.419 Shoulder Joint Swelling

__M25.522 Left Elbow Pain
__M25.521 Right Elbow Pain
__S53.499A Elbow Sprain/Strain
__M25.9 Disorder of Elbow
__M25.429 Elbow Swelling
__M70.20 Olecranon Bursitis
__M99.07 Upper Extremity Somatic Dysfunction

__M25.552 Left Hip Pain
__M25.551 Right Hip Pain
__M24.1529 Pelvic Cartilage Disorder
__M79.652 Left Thigh Pain
__M79.651 Right Thigh Pain
__S73.192A Left Hip & Thigh Sprain/Strain
__S73.191A Right Hip & Thigh Sprain/Strain
__S76.3995 Hamstring Tendon Division

__M25.562 Left Knee Pain
__M25.561 Right Knee Pain
__M23.90 Derangement of Knee
__S83.90XA Knee Sprain/Strain
__M25.9 Knee/Ankle Disorder
__M25.469 Knee Swelling
__M70.50 Knee Bursitis

__M79.604 Rt Leg Pain
__M79.605 Lt Leg Pain
__M79.671 Rt Foot Pain
__M79.672 Lt Foot Pain
__S93.609A Foot Sprain
__M99.06 LE Somatic Dysfunction

__R51 Headache
__R41.3 Short Term Memory Loss
__G44.319 Acute Posttraumatic HA
__F44.89 Confusional State
__V43.52 Car Driver Injured In Collision
__G47.9 Sleep Disorder
__R29.3 Antalgic Posture
__R53.2 Immobile
__G82.50 Tetraplegia/Quadriplegia
__Z73.89 Difficulty Coping w/ Pain
__M53.80 Intervertebral Disc Rupture
__M51.35 Intervertebral Disc Tear
__G95.20 Spinal Cord Compression
__M62.9 Myopathy
__R60.0 UE/LE Edema
__M65.9 Synovitis/Tenosynovitis
__M62.838 Smooth Muscle Spasm
__M25.60 Joint Stiffness (ROM)
__M71.50 Bursitis
__M60.9 Myostitis
__G99.0 Peripheral Neuropathy
__R20.2 Parasthesa
__M26.609 TMJ
__S06.9X0A Traumatic Brain Injury
__F07.81 Post Concussion Syndrome
__H93.19 Tinnitus
__F43.10 PTSD

__S20.00XA Breast Contusion
__S20.20XA Thorax Contusion
__S30.1XXA Abdominal Wall Contusion
__S30.0XXA Low Back/Pelvis Contusion
__S20.229 Scapular Region Contusion

Provider Signature: _____ Date:_____

The undersigned insured person or guardian of such person affirms: The service(s) set forth above were actually and fully explained to me. I was not solicited by any person to seek services from the medical provider of the services provided above.

Patient/Guardian Signature: _____ Date: _____

Pain Level Chart

Name: _____

Date: _____

Please circle your pain rate on a scale of 1-10 with 1 being the least and 10 being the most amount of pain.

BODY AREA	**PAIN LEVELS**										
Headache:	NONE	1	2	3	4	5	6	7	8	9	10
Neck Pain:	NONE	1	2	3	4	5	6	7	8	9	10
Middle Back:	NONE	1	2	3	4	5	6	7	8	9	10
Lower Back:	NONE	1	2	3	4	5	6	7	8	9	10
Left Arm/Wrist:	NONE	1	2	3	4	5	6	7	8	9	10
Right Arm/Wrist:	NONE	1	2	3	4	5	6	7	8	9	10
Left Shoulder:	NONE	1	2	3	4	5	6	7	8	9	10
Right Shoulder:	NONE	1	2	3	4	5	6	7	8	9	10
Left Leg/Hip	NONE	1	2	3	4	5	6	7	8	9	10
Right Leg/Hip	NONE	1	2	3	4	5	6	7	8	9	10
Left Knee/Ankle	NONE	1	2	3	4	5	6	7	8	9	10
Right Knee/Ankle	NONE	1	2	3	4	5	6	7	8	9	10
OTHER:											
	NONE	1	2	3	4	5	6	7	8	9	10
	NONE	1	2	3	4	5	6	7	8	9	10
	NONE	1	2	3	4	5	6	7	8	9	10

Please circle where your pain is located on the body below.