* 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:						
			Race:			
DOB:						
Home Phone:		Cell Phone:				
Address:						
City:						
Occupation:	Employer: _		Work Phone:			
Marital Status:	Email Address:					
Auto Insurance: Name of Insured: Policy#: Group#: Claim# Attorney Information Name of Attorney: Phone#: Address: City:	State:	Zip:				
patient, with the patient'	s first day of treatment rection to pay, which patient has also grant	nt occurring on the patient has di ed us a lien on the	rected you to send all payments for services rendered benefits.			
		X				
Authorized Representativ			nature			

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? \Box Yes \Box No
Were you wearing a seat belt? \square Yes \square No	
What part of the vehicle was hit?	
Did you go to the hospital? \square Yes \square No	
If yes, which hospital?	
Were you admitted? \square Yes \square No	
Discharge Date:	
First date you sought treatment:	
Are you getting therapy? \square Yes \square No	
How often?	
Are you able to work? \square Yes \square No	
Are you able to sleep? \square Yes \square No	
Is there any other information that is important f	for your condition?
Current Health Information	
Current Health Information	
Tobacco Use? □Yes □No □Former Smoke	er
Alcohol Use? ☐ Yes ☐ No	-
, modifier esc. — res — — — — — — — — — — — — — — — — — — —	
Any allergies to medications? ☐Yes ☐No	
If yes, please list:	
, , ,	
Please list any current medications that you are t	aking and their strengths:
(Include any over the counter medications such a	as ibuprofen, tylenol, etc.)
Patient Signature:	Date:

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:	

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.

Patient Signature:				
	Date: _			

By signing below I agree to all above statements.

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 either 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.



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 be provided.	elow were actually rendered. This me	eans that those services have already been
Initial Consultation		
2. I have the right and the duty to conf	firm that the services have already been	n provided.
3. I was not solicited by any person to	seek any services from the medical pro	ovider 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 by my motor vehicle insurer. If entitled, r	•	tion of any reduction in the amounts paid amount of the reduction, up to \$500.
Insured Person (patient receiving treatme	nt or services) or Guardian of Insured I	Person:
Name (PRINT or TYPE)	Signature	Date
The undersigned licensed medical profess and also:	sional or medical director, if applicable	e, affirms the statement numbered 1 above
A. I have not solicited or caused the instanke a claim for Personal Injury Protection	•	otor vehicle accident, to be solicited to
B. The treatment or services rendered w person to sign this form with informed co		his or her guardian, sufficiently for that
		provisions and all relevant information has esponded to truthfully , accurately , and in
D. The coding of procedures on the accupcoded, unbundled, or constitutes an ir 627.732(14) and (15), Florida Statutes or	nvalid or not medically necessary dia	gnostic test as defined by Section
Licensed Medical Professional Rendering <i>hand</i>):	g Treatment/Services or Medical Direct	tor, if applicable (Signature by his/her own
John L. Wheeler, ARNP		
Name (PRINT or TYPE)	Signature	Date
Any person who knowingly and with inte application containing any false, incompl 817.234(1)(b), Florida Statutes.	•	surer files a statement of Claim or an of a felony of the third degree per Section

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

M54.2 Cervical Radiculopathy M54.12 Cervical Radiculopathy M59.90 Cervical Disc Disorder M50.90 Cervical Disc Disorder w/ Myelopathy M50.90 Cervical Disc Disorder w/ Radiculopathy M50.90 Cervical Disc Disorder w/ Radiculopathy M50.00 Cervical Disc Disorder w/ Radiculopathy M50.00 Cervical Disc Disorder w/ Radiculopathy M50.90 Cervical Sprain/Strain M53.40XA Cervical Sprain/Strain M75.80 Infraspinatus Fradonitis M43.6 Torticollis M75.91 Rt Shoulder Tendonitis M75.91 Shoulder Tendonitis M75.9	OFFICE VISITS: _	99205 HIGH COMPLEXITY	99204 MODERATE COMPLEXITY	_97535 HOME MANAGEMENT TRAINING
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MSD.90 Cervical Disc Disorder MSD.00 Cervical Disc Disorder w/ Myelopathy MSD.01 Cervical Disc Disorder w/ Radiculopathy S46.812A Trapezius Strain MSD.01 Cervical Disc Disorder w/ Radiculopathy S46.812A Trapezius Strain MSD.01 Cervical Disc Disorder w/ Radiculopathy S46.019 Kaptanyasinatus-Infraspinatus Strain MSD.91 Cervical Disc Disorder MSD.01 Cervical Disc Disorder MSD.01 Cervical Disc Tear MSD.01 Cervical Disc Tear MSD.01 Cervical Disc Tear MSD.03 Cervical Disc Tear MSD.03 Cervical Disc Tear MSD.03 Cervical Vertigo MSD.03 Cervical Vertigo MSD.04 Cervical Vertigo MSD.04 Cervical Vertigo MSD.05 Cervical Vertigo MSD.05 Cervical Vertigo MSD.07 Cervical Memiation MSD.07 Cervical Memiation MSD.07 Cervical Hemiation MSD.	M54.2 Cervicalgia		M25.619 Shoulder Stiffness	M79.605 Lt Leg Pain
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M51.36 Lumbar Disc TearS76.3995 Hamstring Tendon DivisionS20.20XA Thor. M40.40 Acquired LordosisS30.1XXA Abdo M40.30 Flattened LordosisM25.562 Left Knee PainS30.0XXA Low S34.21XA Lumbar Nerve InjuryM25.561 Right Knee PainS20.229 Scapul M99.03 Lumbar Segmental DysfunctionM23.90 Derangement of Knee M54.32 Lt Sided Piriformis SyndromeS83.90XA Knee Sprain/Strain		rain		600 0004 0
M40.40 Acquired LordosisS30.1XXA Abdot M40.30 Flattened LordosisS30.0XXA Low S34.21XA Lumbar Nerve InjuryM25.561 Right Knee PainS20.229 Scapul M99.03 Lumbar Segmental DysfunctionM23.90 Derangement of Knee M54.32 Lt Sided Piriformis SyndromeS83.90XA Knee Sprain/Strain				S20.00XA Breast Contusion
M40.30 Flattened Lordosis			576.3995 Hamstring Tendon Division	S20.20XA Thorax Contusion
S34.21XA Lumbar Nerve Injury M25.561 Right Knee Pain S20.229 Scapul M99.03 Lumbar Segmental Dysfunction M23.90 Derangement of Knee S83.90XA Knee Sprain/Strain	<u>-</u>			S30.1XXA Abdominal Wall Contusi
M99.03 Lumbar Segmental DysfunctionM23.90 Derangement of Knee M54.32 Lt Sided Piriformis SyndromeS83.90XA Knee Sprain/Strain				S30.0XXA Low Back/Pelvis Contusi
M54.32 Lt Sided Piriformis SyndromeS83.90XA Knee Sprain/Strain	=			S20.229 Scapular Region Contusion
· - · · · ·	•	•		
INID4.31 KL Diaea PITITOTMIS DynaromeNIZ5.9 Knee/Ankle Disorder		•		
MED 2 Community Date:		synarome		
M53.3 Coccyx PainM25.469 Knee Swelling	IVIS3.3 COCCYX Pain			
M70.50 Knee Bursitis			ivi/0.50 knee Bursitis	

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.

