PATIENT INFORMATION

FIRST NAME:_____ MI:____ LAST NAME:_____ DATE:_____
NOMBRE INICIAL APELLIDO FECHA

DATE OF BIRTH:_____ SOC SEC #:_____ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE:_____
DIRECCION CIUDAD ESTADO CODIGO POSTAL

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____
ELEFONO DE CASA TELEFONO DE TRABAJO TELEFONO CELLULAR

E-MAIL_____
CORREO ELECTRONICO

EMPLOYER:_____ OCCUPATION:_____
EMPLEADOR POSICION

EMERGENCY

CONTACT_____ PHONE:_____ RELATIONSHIP:_____
CONTACTO DE EMERGENCIA TELEFONO PARENTESCO

REFERRING DR./PRIMARY DR:_____ **PHONE:**_____
DOCTOR QUE LO REFIERE/MEDICO DE CABECERA TELEFONO

LANGUAGE PREFERENCE:_____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME:_____ MI: _____ LAST NAME:_____ RELATIONSHIP:_____
NOMBRE INICIAL APELLIDO PARENTESCO

DATE OF BIRTH:_____ SOC SEC#:_____ SEX: ☐ FEMALE ☐ MALE
FECHA DE NACIMIENTO SEGURO SOCIAL SEXO FEMENINO MASCULINO

ATTORNEY NAME:_____ PHONE NUMBER:_____

INSURANCE INFORMATION

☐ **MEDICARE** ☐ **MEDICAID** ☐ **AUTO** ☐ **WORKERS COMP** ☐ **COMMERCIAL** ☐ **SELF PAY**

PRIMARY INSURANCE:_____
SEGURO PRIMARIO

SECONDARY INSURANCE:_____
SEGURO SECUNDARIO

ATTORNEY NAME:_____

DISCLAIMER AND INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. 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 hereby request and authorize **Physical Therapy Institute and Aquatic Rehab, Inc./ Royal Palm Beach Rehab, Corp. / Action Physical Therapy, LLC. / Florida Orthocare Network, LLC** To perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment.

PATIENT'S SIGNATURE_____ **DATE**_____
FIRMA DEL PACIENTE FECHA

WITNESSED BY_____ **DATE**_____
ATESTIGUADO POR FECHA

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat The patient. I am the patients' legal guardian.

GUARDIAN'S SIGNATURE_____ **DATE**_____
FIRMA DEL REPRESENTANTE LEGAL

Patients Name: _____

Patients Height: _____

Patients Weight: _____

BMI: _____

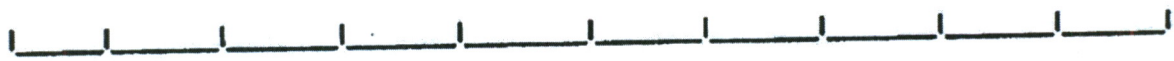
Medication List: **(Please list ALL of the medications you are currently taking)**

Medication Name	Dosage	Frequency	Route (by mouth or injection)	Other

Simple Descriptive Pain Intensity Scale

No Pain **Mild** **Moderate** **Severe** **Very Severe** **Worst Possible**

0-10 Numeric Pain Intensity Scale



0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain **Moderate Pain** **Worst Possible Pain**

Visual Analog Scale (VAS)

No Pain

Pain as bad as it could possibly be

Patients Signature: _____

Medical History

PATIENT NAME_____ DATE _____

PAST MEDICAL HISTORY - Have you had any of the following symptoms or conditions:

Allergies	YES	NO	Foot Troubles	YES	NO	Rheumatic Fever	YES	NO
Anemia	YES	NO	Gall Bladder	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Pacemaker	YES	NO	Severe Headaches	YES	NO
Broken Bones	YES	NO	Head Injury	YES	NO	Shortness of Breath	YES	NO
Cancer	YES	NO	Heart Trouble	YES	NO	Yellow Jaundice	YES	NO
Diabetes	YES	NO	Hernia	YES	NO	Varicose Veins	YES	NO
Ear Trouble	YES	NO	High Blood Pressure	YES	NO	Tumor	YES	NO
Epilepsy	YES	NO	Kidney Trouble	YES	NO	Tuberculosis	YES	NO
Eye Trouble	YES	NO	Mental or Nervous	YES	NO	Skin Conditions	YES	NO
Fainting Spells	YES	NO	Disorders	YES	NO	HIV	YES	NO

Are you presently under a Doctor's care for any condition? YES NO Please Explain _____

_____

Do you have allergies to any medication? YES NO Please Explain _____

_____

Current Subjective Complaints

Date symptoms started : _____

Please describe your condition and how it happened: _____

_____

What activities if any make your condition better? _____

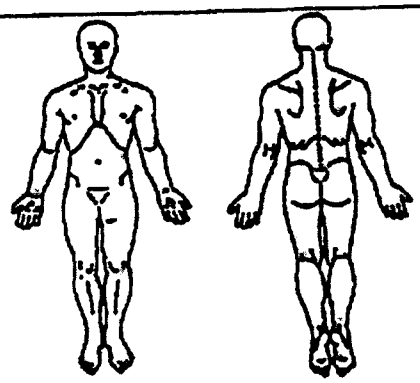
_____

Date of last X-Rays_____ What body part were taken? _____

WOMEN ONLY ARE YOU PREGNANT? YES NO Date of last Menstrual Cycle _____

Please mark the diagram below to point out where your pain is:

HEAD
____ Headaches - How often? _____
____ Light Headed
____ Double Vision
____ Hearing Loss
____ Memory Loss
____ Ringing in Ears
____ Fainting
____ Blurred Vision
____ Loss of Balance
____ Dizziness
____ Sensitive to Light
____ TMJ / Jaw Symptoms



Action Physical Therapy LLC Financial Policy/Assignment of Benefits

Thank you for choosing Action Physical Therapy , LLC as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Action Physical Therapy, LLC and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Action Physical Therapy, LLC, when which checks, drafts or money orders are made payable for services which have been rendered by Action Physical Therapy, LLC, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Action Physical Therapy, LLC. Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms.

The undersigned by these present does give & grant the said Action Physical Therapy, LLC. as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Action Physical Therapy, LLC. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Action Physical Therapy, LLC.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Action Physical Therapy, LLC. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Action Physical Therapy, LLC.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor)_____Date:_____

Patients Name (Please Print):_____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Action Physical Therapy LLC will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Physical Therapy Institute & Aquatic Rehab Inc Financial Policy/Assignment of Benefits

Thank you for choosing Physical Therapy Institute & Aquatic Rehab Inc as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Physical Therapy Institute & Aquatic Rehab Inc and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & In the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Physical Therapy Institute & Aquatic Rehab Inc, when which checks, drafts or money orders are made payable for services which have been rendered by Physical Therapy Institute & Aquatic Rehab Inc, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Physical Therapy Institute & Aquatic Rehab Inc. Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms. The undersigned by these present does give & grant the said Physical Therapy Institute & Aquatic Rehab Inc as attorney the full power and authority to do or and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Physical Therapy Institute & Aquatic Rehab. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Physical Therapy Institute & Aquatic Rehab Inc.
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Physical Therapy Institute & Aquatic Rehab Inc. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in
Florida Statutes for any services and/or charges provided by Physical Therapy Institute & Aquatic Rehab Inc

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor)_____Date:_____

Patients Name (Please Print):_____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Physical Therapy Institute & Aquatic Rehab Inc will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab Corp Financial Policy/Assignment of Benefits

Thank you for choosing Royal Palm Beach Rehab Corp as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Royal Palm Beach Rehab Corp and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & In the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Royal Palm Beach Rehab Corp, when which checks, drafts or money orders are made payable for services which have been rendered by Royal Palm Beach Rehab Corp, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Royal Palm Beach Rehab Corp, Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms. The undersigned by these present does give & grant the said Royal Palm Beach Rehab Corp as attorney the full power and authority to do or and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Royal Palm Beach Rehab Corp. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Royal Palm Beach Rehab Corp
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Royal Palm Beach Rehab Corp. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Royal Palm Beach Rehab Corp.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor)_____Date:_____

Patients Name (Please Print):_____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab Corp will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Florida Orthocare Network LLC Financial Policy/Assignment of Benefits

Thank you for choosing Florida Orthocare Network LLC as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial policy is as stated:

- All copays & deductibles are due at the time of service
- Payment of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THIS POWER OF ATTORNEY IS ONLY TO ALLOW US TO INDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE/ATTORNEY TO PAY FOR YOUR SERVICES.

Know by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute & appoint Florida Orthocare Network LLC and any of its duly authorized agents and employees as to be the undersigned's true & lawful attorney for & In the undersigned 's name, place & stead to endorse any/all checks, drafts or money order which are made payable to the undersigned alone or to the undersigned and said Florida Orthocare Network LLC, when which checks, drafts or money orders are made payable for services which have been rendered by Florida Orthocare Network LLC, at the request or with the knowledge and approval of the undersigned and/or the make of the check, drafts or money order. Furthermore, the undersigned allows Florida Orthocare Network LLC, Or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and/or other forms. The undersigned by these present does give & grant the said Florida Orthocare Network LLC as attorney the full power and authority to do or and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purposes as the undersigned might could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me The patient, to release true copies of the same to Florida Orthocare Network LLC. or any insured providing the coverage to me in connection with the process of any other claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, _____, hereby authorize_____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make payable directly to: Florida Orthocare Network LLC
Payable & mailed directly to: 4971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Florida Orthocare Network LLC. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Florida Orthocare Network LLC

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____

Signature of Patient (parent/guardian, if minor)_____Date:_____

Patients Name (Please Print):_____

Insurance

We accept all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Royal Palm Beach Rehab Corp will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & represent a referral at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please ask our Front Desk Coordinator.

Royal Palm Beach Rehab Corp., Physical Therapy Institute and Aquatic Rehab, Action Physical Therapy LLC, and Florida Orthocare Network LLC

Notice of Privacy Practices

Date: _____

Patient Name: _____

This is to certify that I, _____ have been given, offered or have seen the posted copy of the Notice of Privacy Practices (also known as HIPPA).

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Signature of Clinic Representative **Date**

Office Use Only
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Form, but was unable to do so as documented below:

Date:	Initials:	Reason:

WRITTEN DISCLOSURE FORM (F.S. 456.052)

Dr. John Papa, DC has a financial interest in the following entities:

ROYAL PALM BEACH REHAB, CORP. DBA ACTION PHYSICAL THERAPY
Offices in Miami, Broward, Palm Beach, Martin (www.actionphysical.com)
ROYAL PALM BEACH REHAB, CORP. DBA FLORIDA ORTHOCARE
Offices in Miami, Broward, Palm Beach, Martin (www.florthocare.com)
CERTIFIED SPINE AND PAIN CARE, LLC
Offices in Miami, Broward, Palm Beach (www.certifiedspineandpain.com)

AS THE PATIENT YOU HAVE A RIGHT TO OBTAIN THE SAME ITEMS/SERVICES AT ONE OF THE ABOVE-LISTED LOCATIONS OR AT A DIFFERENT LOCATION OF YOUR CHOICE. YOU MAY OBTAIN THESE SAME ITEMS/SERVICES AT THE FOLLOWING LOCATIONS WHERE DR. JOHN PAPA, DC, DOES NOT HAVE A FINANCIAL INTEREST:

MIAMI-DADE COUNTY
- Pain Medicine, Baptist Health, 13101 S. Dixie Highway, Suite 400, Miami, FL 33156
- Advanced Institute for Pain Management, University of Miami, 1120 NW 14 Street, 9th Floor, Suite 101, Miami, FL

BROWARD COUNTY
- American Pain Experts, 1164 E. Oakland Park Blvd., Suite 201, Oakland Park FL, 33334
- Broward Health Pain Management, 2100 E Sample Road, Suite 203, Lighthouse Point, FL 33064

PALM BEACH COUNTY
- National Pain Institute, 5365 West Atlantic Avenue, Suite 504, Delray Beach, FL 33484
- Resolute Pain Solutions, 4510 Donald Ross Road, Palm Beach Gardens, FL 33418

MARTIN COUNTY
- Pain Management, Martin Health, 509 Riverside Dr., Suite 203, Stuart, FL 34994
- Resolute Pain Solutions, 2100 SE Ocean Boulevard, Suite 100, Stuart, FL 34996

_____ _____
Patient Signature Date

The 2018 Florida Statutes

Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

View Entire Chapter

456.052 Disclosure of financial interest by production.—

(1) A health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

(a) The existence of the investment interest.

(b) The name and address of each applicable entity in which the referring health care provider is an investor.

(c) The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor.

(d) The names and addresses of at least two alternative sources of such items or services available to the patient.

(2) The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in his or her office.

(3) A violation of this section shall constitute a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. In addition to any other penalties or remedies provided, a violation of this section shall be grounds for disciplinary action by the respective board. **History.**—s. 1, ch. 86-31; s. 84, ch. 91-224; s. 13, ch. 92-178; s. 92, ch. 97-261; s. 76, ch. 2000-160.

Note.—Former s. 455.25; s. 455.701.

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.**

_____

_____

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 (15) and (16), 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

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.

OIR-B1-1571
Pub. 1/2004

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.**

_____

_____

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 (15) and (16), 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

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.

OIR-B1-1571
Pub. 1/2004

Notice of Doctor's Lien

Please sign and fax back to 561-791-9071

TO: ATTORNEY:

_____

_____

Royal Palm Beach Rehab Corp.

106 Ponce De Leon St

Royal Palm Beach, FL 33411

561-791-9090

Re: Medical Reports & Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, Diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay said doctor such sums as may be due and owing for his/her medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement 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 said doctor for all medical and/or surgical benefits Including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctors additional protection. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or court costs will be added to the total amount due.

Date:_____ Patient Name:_____

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums settlement, judgement, or verdict as may be necessary to adequately protect said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment, The prevailing party ion any litigation resulting from enforcement of this lien shall be entitled to equal attorney's fees and court cost.

Date:_____Attorney Signature:_____

Attorney: Please date, sign and return one copy to the above doctor's office immediately.

Please keep on copy for you records.

PERSONAL INJURY PATIENT HISTORY

Name_____ Date_____

History
Date of Accident_____ Time of Accident_____ AM PM

_____Neck Pain Mild Moderate Severe
_____Low Back Pain Mild Moderate Severe
_____Mid Back Pain Mild Moderate Severe
_____Shoulder Pain R L Mild Moderate Severe
_____Headaches Mild Moderate Severe
_____Knee Pain R L Mild Moderate Severe

In your own words, describe how the accident happened_____
_____
_____
_____

Were you wearing your seatbelt? ___Yes ___No Did you see the accident coming ___Yes ____No.
Did you brace for the impact? __Yes __No __I braced with my hands, __I braced with my feet,__
Other
Did you strike anything within your vehicle at the time of impact?__ Yes___ No___ Not Sure
If Yes,
What_____
Did the seat back break? ____Yes ____No Describe any cuts or
bruises_____
Immediately following the accident, how did you feel? ___Dizzy/Dazed ___Disoriented ___Confused _Nervous
___Nauseous ____Upset ____Weak _____Shaken Up
Were you knocked unconscious? If so, how long _____
Did you go to the hospital? __Yes __No Which hospital? _____When_____
How did you get to the hospital? __Ambulance __Drove myself ___ Someone else drove me (who)
___
Were X-Rays taken at the hospital? __Yes __No Prescribed Medication? __Yes __No What type _____
List any other doctor you may have seen as a result of this accident
Date _____ Doctors Name _____
Date _____ Doctors Name _____

Past History
Have you been involved I a previous Motor Vehicle Accident? __Yes __No Please Describe _____
_____
Did you have any physical complaints before this accident __Yes __No Please Explain _____
_____

Work Status
Occupation _____ Employer _____
Have you missed work ___Yes ___No Dates of Loss_____ Have you returned to work__Yes__No

Please list any restrictions you have been placed on _____
What activities, if any, aggravate your condition at work _____