PROSPORTS / PROSPINE

Please Fill This Form Out Completely

Name:_____DOB:_____Age:_____Date:_____

Occupation:_____ Height: _____ Weight:_____

Pharmacy Name:_____ Location or phone #:_____

Referring Physician:_____Family Physician:_____

History of Present Illness/Condition

Reason you are seeing the doctor today?:_____

How did you injure yourself?_____

Have you been treated previously for this problem? No ( ) Yes ( ) Where?:_____

Previous X-Ray or MRI for this problem? No ( ) Yes ( ) Where?:_____

Past Medical History

Are you allergic to any medications?: No ( ) Yes ( ) if yes please list:_____

Are you **right** ( ) or **left** handed ( ) Can you possibly be pregnant? No ( ) Yes ( )

Anemia	**No ( ) Yes ( )**	**Lung or Breathing Problems**	**No ( ) Yes ( )**
Arthritis	**No ( ) Yes ( )**	**Mental Illness**	**No ( ) Yes ( )**
Rheumatoid Arthritis	**No ( ) Yes ( )**	**Peptic Ulcer**	**No ( ) Yes ( )**
Asthma/Emphysema	**No ( ) Yes ( )**	**Psoriasis**	**No ( ) Yes ( )**
Bleeding Disorders	**No ( ) Yes ( )**	**Pulmonary Embolus**	**No ( ) Yes ( )**
Cancer	**No ( ) Yes ( )**	**Seizures**	**No ( ) Yes ( )**
Where?_____		**Stroke**	**No ( ) Yes ( )**
Diabetes	**No ( ) Yes ( )**	**Venous Thrombosis**	**No ( ) Yes ( )**
Gout	**No ( ) Yes ( )**	**Pacemaker**	**No( ) Yes ( )**
Heart Disease	**No ( ) Yes ( )**		
High Blood Pressure	**No ( ) Yes ( )**	**Other**_____	
High Cholesterol	**No ( ) Yes ( )**		
HIV AIDS	**No ( ) Yes ( )**		

Have you had any surgeries in the past? If yes, please list type and date of surgery:_____

_____

Have you had any complications with anesthesia? If yes, please explain:_____

Social History

Marital Status: S M W D Ethnicity:_____Race:_____Preferred Language:_____

Smoke Currently? No ( ) Yes ( ) If no, when did you quit?:_____

Drink Alcohol? _____never _____occasional _____ moderate to heavy _____family history

Drug Overuse? _____never _____present _____past problem

Reviewed with patient: _____MD

PROSPORTS/PROSPINE

MEDICATION LIST

PLEASE PRINT

Patient Name: _____ D.O.B.: _____

Are You Allergic To Any Medications? :_____

NAME OF MEDICATION	STRENGTH (MILLIGRAMS, GRAMS)	DOSAGE (HOW MANY TIMES A DAY?)	WHO PRESCRIBED?

If You Need More Space, Please Write "See List" And Attach A List.

Please List Any Over the Counter Medications/Supplements That You Take:_____

_____

_____

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PROSPORTS/PROSPINE

PAST MEDICAL HISTORY

Patient Name: _____ D.O.B.: _____

Please Check Each Item "Yes" Or "No"

GENERAL

WEIGHT LOSS	No ( ) Yes ( )
FEVER	No ( ) Yes ( )
CHILLS	No ( ) Yes ( )
NIGHT SWEATS	No ( ) Yes ( )

EYES/VISION

VISUAL CHANGES	No ( ) Yes ( )
CATARACTS	No ( ) Yes ( )
GLAUCOMA	No ( ) Yes ( )

EARS

HEARING LOSS	No ( ) Yes ( )
PAIN	No ( ) Yes ( )
RINGING	No ( ) Yes ( )
DIZZINESS/VERTIGO	No ( ) Yes ( )

NOSE

NOSE BLEEDS	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )
RUNNY NOSE	No ( ) Yes ( )
INJURY	No ( ) Yes ( )

THROAT

FREQ. SORE THROATS	No ( ) Yes ( )
DIFFICULTY SWALLOWING	No ( ) Yes ( )
HOARSENESS	No ( ) Yes ( )
FOREIGN BODY	No ( ) Yes ( )

HEART

HIGH BLOOD PRESSURE	No ( ) Yes ( )
CHEST PAIN	No ( ) Yes ( )
IRREGULAR HEART BEAT	No ( ) Yes ( )
PREVIOUS HEART ATTACK	No ( ) Yes ( )

LUNGS

BRONCHITIS	No ( ) Yes ( )
ASTHMA/WHEEZING	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )

GASTROINTESTINAL

INDIGESTION/HEARTBURN	No ( ) Yes ( )
ULCERS	No ( ) Yes ( )
GALLBLADDER	No ( ) Yes ( )
DIARRHEA	No ( ) Yes ( )
DIVERTICULITIS	No ( ) Yes ( )
NAUSEA/VOMITING	No ( ) Yes ( )

URINARY TRACT

KIDNEY PROBLEMS	No ( ) Yes ( )
PAINFUL URINATION	No ( ) Yes ( )
BLOOD IN URINE	No ( ) Yes ( )
PROSTATE PROBLEMS	No ( ) Yes ( )

MUSCULOSKELETAL

BACK PAIN	No ( ) Yes ( )
WEAKNESS	No ( ) Yes ( )
ARTHRITIS	No ( ) Yes ( )

NEURO/PSYCHOLOGICAL

NUMBNESS	No ( ) Yes ( )
MIGRAINES	No ( ) Yes ( )
SEIZURES	No ( ) Yes ( )
CONVULSIONS	No ( ) Yes ( )
STROKE	No ( ) Yes ( )
DEPRESSION	No ( ) Yes ( )

ENDOCRINE

THYROID DISORDERS	No ( ) Yes ( )
DIABETES	No ( ) Yes ( )
MENOPAUSE	No ( ) Yes ( )
HORMONE REPLACEMENT	No ( ) Yes ( )

BLOOD DISORDERS

LOW BLOOD COUNTS	No ( ) Yes ( )
BLOOD CLOTS	No ( ) Yes ( )
HEPATITIS	No ( ) Yes ( )
HIV/AIDS	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

Other past medical history not mentioned

_____

PROSPORTS/PROSPINE

DEMOGRAPHIC SHEET

Patient Name: _____ Social Security # _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Mailing Address: _____City_____State_____ Zip: _____

Seasonal Address: _____City_____State_____ Zip: _____

Home Telephone #: _____ Cellular #:_____

Email Address: _____

Employer: _____ Employer Telephone #: _____

Emergency Contact: _____ Contact #:_____

If Not Referred By A Physician, Who Referred You:

_____Newspaper _____Radio _____Yellow Pages _____Community Event _____ Movie Theater

_____Friend Or Acquaintance – Name (Optional) _____

Financially Responsible Person (If Different Than Above)

Name: _____ Social Security # _____

Date of Birth: _____ Relationship to patient: _____ Age: _____

Mailing Address: _____ City _____State_____ Zip: _____

Employer: _____ Employer Telephone #: _____

Please Check Which One Applies To You

_____ Worker's Compensation Date of Injury: _____/_____/_____

Describe Type and Location of Injury: _____

_____ Auto Accident Date of Injury: _____/_____/_____

Describe Type and Location of Injury: _____

_____ Law Suit : Name Attorney_____ Telephone #: _____

Describe Type and How Injury Occurred: _____

_____ Other Accident or Injury Date of Injury or Onset: _____/_____/_____

Describe Type and Location of Injury: _____

_____ None of the Above: Describe the Problem:_____

_____

PROSPORTS/PROSPINE

INSURANCE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Insurance Information

We will need a copy of all insurance cards and a photo ID for our records.

Primary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Secondary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Patient/Insurance Signature Authorization
Medicare and All Other Insurance

I consent to treatment necessary for the care of the above named patient.

I authorize Peter G. Wernicki, M.D, M. Christopher Talley, M.D., Johnny C. Benjamin, M.D. and William P. Cooney, M.D. to appeal any claims on my behalf to my insurance company.

I authorize the release of my medical records to the referring/family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by ProSports &ProSpine.

I understand that payment of the charges incurred, including copays, deductibles, or co-insurance is due at the time services are rendered unless prior financial arrangements have been made with our management. Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the initial $15.00 administrative fee for balances not paid in full.

If I default on my account, I agree to pay all reasonable attorney fees, interest on account, and collections costs. The collection fees are 32% for current outstanding balances and 50% for balances greater than one year.

I request that payment of authorized Medicare benefits and/or any other insurance carrier benefits be made on my behalf to Peter G. Wernicki, M.D., M. Christopher Talley, M.D., Johnny C. Benjamin, M.D. and William P. Cooney, M.D. The Medicare provider agrees to accept the Medicare assignment and the patient is responsible for the deductible, co-insurance, and non-covered services.

I have read and fully understand the above and I consent to treatment, financial responsibility, release of medical information, and insurance authorization.

Patient's Or Parent/Guardian Signature _____ Date: _____

PROSPORTS / PROSPINE

Dear Patients:

The following information is for your convenience and is provided to help you understand and give consent to some of our policies and procedures.

- Insurance co-pays, deductibles, and any co-insurance are due at the time that services are rendered. If payment is not received, there will be a $15.00 administrative fee added to your balance. If we do not participate with your insurance company, payment is due in full at the time services are rendered. There will be a $25.00 fee for all returned checks. We can file your insurance as a courtesy.

- **Medicare Patients-** If you are a Medicare member, you will be responsible to sign and review the Advanced Beneficiary Notice (ABN), for services non-covered or deemed not Medically Necessary by Medicare. If the patient has no secondary insurance you will be responsible for the 20% co-insurance. We do not participate with any HMO policies. It is your responsibility to know your policy and if we participate with your Medicare Advantage plan.

- **Other entities-** During your course of treatment, you may be referred to other institutions for treatment. These referrals are based on solely medical necessity and our affiliations with these institutions are based on providing our patients with the highest quality and medical care possible. ProSports & ProSpine will make every effort in sending you to a participating facility through your insurance company, but it is ultimately the patients' responsibility. At your request we can provide other entities for your treatment. The centers you may be referred to that we have affiliations with are:

  Medical Specialty Procedures
  Pro Therapy
  ProSpine Electro diagnostic testing

- Prescription refills will be called in by 5:00 pm. Please check with your pharmacy prior to calling the office to see if your prescription has been received. Prescriptions will **NOT** be called in after 5:00 pm Monday-Thursday and Friday after 3:30 pm or on weekends.

- ProSports and ProSpine take pride in improving your health record. We have begun the first stage of Electronic Health Record which is Electronic Prescriptions. This enables us to receive your last 13 months of medication history for medications prescribed to you through electronic processing. It will not include every medication you take. ProSports & ProSpine will submit any medications electronically that is authorized. I understand and agree that my medication history may be requested from other healthcare providers or third party pharmacies and used for treatment purposes. If you have provided an email address we will send a secured link to a website for your review of the clinical summary from your visit with ProSports & ProSpine.

- ProSports & ProSpine require necessary paperwork, diagnostic testing film and results. Without such paperwork, your appointment may need to be rescheduled. If you are late for an appointment, we may need to reschedule you to accommodate patients who are on time for their appointments.

- There is a $20.00 charge for any disability or insurance forms that need to be completed. Please allow (7) seven days for the paperwork to be completed. Payment is required prior to forms being completed.

- When copies of X-Rays/ or medical records are needed, we require a 24-48 hour notice. If your MRI needs to be filmed we require (5) working days. There is a fee of $20.00 to transfer/ film MRI or X-Rays to CDs and a $1.00 per page for copying medical records.

Your signature below acknowledges that you understand all of the above policies and procedures.

_____ _____

Patient Signature Date

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ProSports / ProSpine
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ProSports & ProSpine are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. The terms of the privacy practices are to provide you with notice of its legal duties and privacy practices regarding your health information.

ProSports & ProSpine reserve the right to change our privacy practices (PHI) and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes.

ProSports & ProSpine may use or disclose as needed, your PHI to medical students that shadow the physicians for training. We may use a sign-in sheet at the registration desk for you to indicate your name and physician you are seeing. We may call you by name in the waiting room. We may leave a voicemail on your phone, unless otherwise notified by the patient, in case of any changes to your appointment.

I acknowledge receipt of the Pro Sports& Pro Spine Notice of Privacy Practices. I understand that, by reading this consent form and signing, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatments, payment activities and healthcare operations.

_____ _____

Printed Name ID Number or SSN

_____ _____

Signature Date of Notification

Below please list the people that we are allowed to release/discuss your information to:

Name (please print)	Relationship to patient
1._____	_____
2._____	_____
3._____	_____
4._____	_____

PROSPORTS / PROSPINE

Notice of Privacy Practices

ProSports and ProSpine are now required by Federal Law to provide you a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review this carefully.

ProSports and ProSpine are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. ProSports and ProSpine reserves the right to change the terms of this notice of privacy and to make any new notice by requesting that all patients read and sign a new and update notice of privacy practice (PHI).

For more information about our privacy practices, or for additional copies of this notice, please contact the office manager at 772-978-7808.

ProSports and ProSpine may access, use or share medical information about you for treatment, payment and healthcare operations;

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. You may revoke this in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Notification to Family and Friends: We may disclose your health information to notify or assist in notifying a family member, your emergency contact or any other person to the extent to help with your healthcare or with payment for your healthcare, but only if you agree that we do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personal under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of PHI of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

Your Rights: You have the right to look at or get copies of your health information, with limited exceptions. If copies are requested, there is a charge for copies. You must make a request in writing to obtain access to your health information. You may change or add information to your health record. The request must be in writing and it must explain why the information should be amended; HOWEVER, ProSports and ProSpine may not change the original documents.

Complaints: If you need more information, have complaints or feel that your privacy rights have been violated contact: Johnny C. Benjamin, MD., 1355 37th Street, Suite 301, Vero Beach, FL 32960. If you are not satisfied with how ProSports &ProSpine handle your concern, you may submit a formal complaint to: DHHS Office of Civil Rights, 200 Independence Ave SW., HHH Building, Washington, DC 20201. If you file a complaint, we will not take any action against you or change our treatment of you in anyway.