PATIENT INFORMATION

First name: _____MI: _____ Last name:_____ Date: _____

Date of Birth: _____ Sex: □ Female □ Male □ Other_____

Address:_____ City: _____ State: _____ Zip Code:_____

Cellphone number: _____ Alternative phone: _____

Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____Relationship: _____

Primary Care Doctor: _____

Language preference: □ English □Spanish □ Other _____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

Name:_____ Initial: _____ Last Name:_____ Relationship: _____

Date of Birth: _____ Sex: □ Female □ Male □ Other_____

INSURANCE INFORMATION

□ Medicare □ Medicaid □ Auto Accident □ Workers Compensation □ Commercial □ None / Self pay

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID:_____

***Accident Related**:* □ Auto □ Slip and Fall □ Workers compensation □ Other_____

Insurance Company: _____ Date of Accident: _____

Claim Number: _____

Attorney Name: _____ Attorney Phone #: _____

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 *Royal Palm Beach Rehab, Corp. / Florida Orthocare Network. LLC,/ Orthopedic Urgent Care Centers of Florida/Jupiter West Medical Center.* 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 Signature: _____ Date: _____

Guardian Signature: _____ Date*:* _____

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 patient's legal guardian

MEDICAL HISTORY

Patient Name: _____ Date: _____

Patient Height: _____ Patient Weight: _____

Past Medical History – Had you had any of the following symptoms or conditions?:

☐ Allergies	☐ Fainting Spells	☐ Mental or nervous problems
☐ Anemia	☐ Gallbladder issues	☐ Rheumatic Fever
☐ Asthma	☐ Pacemaker	☐ Rheumatoid arthritis
☐ Broken bones	☐ Head injury	☐ Migraines or headaches
☐ Cancer	☐ Cardiac or heart problems	☐ Difficulty breathing
☐ Diabetes	☐ HIV	☐ Skin infections or problems
☐ Ear Trouble	☐ Hernia	☐ Varicose Veins
☐ Epilepsy	☐ High blood pressure	☐ Tumor
☐ Ocular problems	☐ Kidney problems	☐ Tuberculosis

Any previous surgeries? ☐ Yes ☐ No When? _____

What body part? _____

Are you currently under any medical treatment for any other condition by another physician or doctor?

☐ Yes ☐ No Please explain:_____

_____

Do you have any allergies, or medical allergies? ☐ Yes ☐ No Please explain: _____

CURRENT SUBJECTIVE COMPLAINTS

Medication list: (Please make a list of all the medications that you are currently taking, including vitamins)

Name of the Medication	Doses	Frequency	Method (oral or injectable)

Date that your symptoms started: _____

Please describe your condition and how it happened: _____

_____

_____

Have you ever had these symptoms before? ☐ Yes ☐ No When?_____

What makes your condition or symptoms worse?: _____

_____

MEDICAL HISTORY CONT.

What makes your condition or symptoms better? _____

_____

Have you seen any other doctor for this condition? □ Yes □ No Doctor name: _____

Date of the last x-ray, MRI, CT-scan, Ultrasound: _____

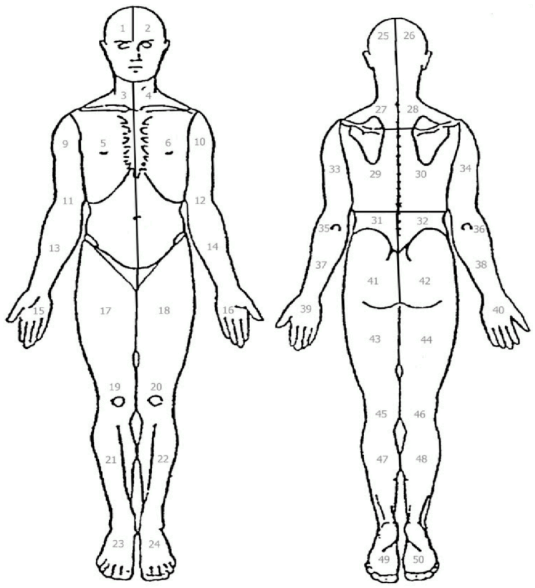
What body part?: _____

Where were the images performed?_____

Only Woman: Are you pregnant? □ Yes □ No Last date of menstrual cycle: _____

Weeks of pregnancy _____

Please mark all the areas that are currently bothering or hurting in the following diagram:



Describe the pain:

- ☐ Burning/throbbing
- ☐ Sharp
- ☐ Tingling
- ☐ Ache/Dull
- ☐ Numbness
- ☐ Electrical
- ☐ Rigidity

Does the pain travel?: □ Yes □ No:
Where?_____

Does the area or any body part "fall asleep" or become numb?
□ Yes □ No: Where?_____

Do you feel any weakness in the area or the body?
□ Yes □ No: Where?_____

Numeric pain scale 0-10

I_____I_____I_____I_____I_____I_____I_____I_____I_____I_____I

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate pain Severe pain Emergency

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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 patient's legal guardian.

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 co pays & deductibles are due at the time of service
- Payment of patient balances is 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 this with our Front Office Coordinator. We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34.00 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 ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE 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 an attorney the full power and authority to do and perform all and 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 *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 an original signature page. The undersigned does hereby ratify and confirm 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 & malted directly to *4*971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits are 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 Networks, LLC. Financial Policy/Assignment of Benefits

Thank you for choosing *Florida Orthocare Networks, 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 co pays & deductibles are due at the time of service
- Payment of patient balances is 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 this with our Front Office Coordinator. We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34.00 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 ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE 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 Networks, 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 Networks, LLC*, when which checks, drafts or money orders are made payable for services which have been rendered by *Florida Orthocare Networks, 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 Networks, 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 Networks, LLC*. as an attorney the full power and authority to do and perform all and 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 *Florida Orthocare Networks, 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 an original signature page. The undersigned does hereby ratify and confirm 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 Networks, LLC*

Payable & malted directly to *4*971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits are otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to *Florida Orthocare Networks, 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 Networks, 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. *Florida Orthocare Networks, 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.

Jupiter West Medical Center Financial Policy /Assignment of Benefits

Thank you for choosing *Jupiter West Medical Center* 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 co pays & deductibles are due at the time of service
- Payment of patient balances is 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 this with our Front Office Coordinator. We accept cash, checks, Visa, Mastercard, Amex & Discover. There is a $34.00 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 ENDORSE AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE 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 *Jupiter West Medical Center* 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 *Jupiter West Medical Center*, when which checks, drafts or money orders are made payable for services which have been rendered by *Jupiter West Medical Center*, 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 *Jupiter West Medical Center.* 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 *Jupiter West Medical Center*. as an attorney the full power and authority to do and perform all and 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 *Jupiter West Medical Center* 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 an original signature page. The undersigned does hereby ratify and confirm 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: *Jupiter West Medical Center*
Payable & malted directly to *4*971 Le Chalet Blvd. Suite 100, Boynton Beach, FL 33436

The medical benefits are otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to *Jupiter West Medical Center* 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 *Jupiter West Medical Center*

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 .*Jupiter West Medical Center* 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., Florida Orthocare Networks LLC., Jupiter West Medical Center & Orthopedic Urgent Care Centers of Florida

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).

_____ _____
Patient/Guardian signature Date

_____ _____
Signature of Clinic Representative Date

Official use only

I attempted to obtain the patient's signature in acknowledgment 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)

ORTHOPEDIC URGENT CARE CENTERS OF FLORIDA

Offices in Palm Beach County (www.orthopedicurgentcarecenters.com)

JUPITER WEST MEDICAL CENTER

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/Guardian Signature _____ Date:_____

The 2018 Florida Statutes

View Entire Chapter

Title XXXII REGULATION OF PROFESSIONS AND OCCUPATIONS
Chapter 456 HEALTH PROFESSIONS AND OCCUPATIONS:

GENERAL PROVISIONS

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.