FLORIDA PHYSICAL MEDICINE PATIENT INFORMATION **Date _____/_____/_____** **Auto 111114**

Name _____ **Social Security #**_____ **Sex: M F Date of Birth**_____/_____/_____ **Age**___

Home Phone (_____**)**_____ **Cell (**_____**)**_____ **Work (**_____**)**_____

Address_____ **City**_____ **State**_____ **Zip Code**_____

Email address _____ **Occupation** _____ **Employer**_____

Marital Status: Single Married Widowed Domestic partner **Person to contact in emergency**_____

Date of the accident _____/_____/_____ **Time**_____ am pm **Location**_____

Were you the driver passenger pedestrian **Were you struck from** behind front left right

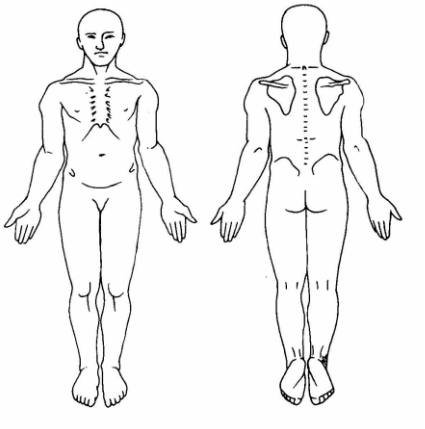
Did another car strike yours? Yes No **Did your car strike another car?** Yes No **Was a citation issued to you?** Yes No

Were you wearing your seatbelt? Yes No **Did the airbags deploy?** Yes No **Did you go to the hospital?** Yes No

Please check the symptoms that you've been experiencing since the accident.

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Back Stiffness
( ) Tension/Nervous
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Please mark the area of pain on the diagram below.



Please answer the following questions to the best of your ability.

1. **Circle the words that describe your pain.**

Aching Sharp Throbbing Tender Nagging Burning

Numb Stabbing Localized Radiating Unbearable Exhausting

2. **Please Circle One:** occasional pain continuous pain

3. **What time of day is your pain the worst?**
Morning Afternoon Evening Nighttime

4. **Rate your pain by circling the number that best describes your pain at its worst.**
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. **Rate your pain by circling the number that best describes your pain on average.**
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. **What makes your pain better?** _____

7. **What makes your pain worse?** _____

8. **Have you missed work?** Yes No **Please list dates** _____

9. **Is your condition preventing you from participating in certain activities**? Yes No
Please list _____

Have you seen anyone else for this condition? Yes No **Name of Primary Dr:** _____

Results of exam/treatment given? _____

Current Medication: Please include all prescription, over-the-counter medications, vitamins, and herbal supplements)

1._____ 2._____

3. _____ 4. _____

5._____ 6._____

Allergies (medication, food, other): Please list and state the reaction you had: _____

_____

Hospitalizations / Surgeries/ Foreign Materials eg. Pacemaker, metal etc. (please list procedures, dates):

_____

_____

Previous Injuries (auto accidents, fractures, etc.) _____

Have you ever had the following:

Heart disease _____ Diabetes _____ Mitral valve prolapsed _____ Glaucoma _____ Tuberculosis _____ HIV/ AIDS _____

Liver Disease_____ Leukemia _____ Stroke _____ Hepatitis _____ Pacemaker _____ Metal implants _____ Sinusitis _____

Hemorrhoids _____ Hives _____ Bronchitis _____ Lung disease _____ Rheumatic fever _____ Kidney disease _____ Thyroid disease _____ Ulcers _____ Psychiatric disorder _____ Heart murmur _____ Colitis _____ Epilepsy _____ Artificial Prosthesis__

Cancer _____ Mono_____ Measles _____ Mumps _____ Chickenpox _____ Whooping cough _____ Scarlet fever ____

Diptheria _____ Smallpox _____ Venereal disease _____ Anemia _____ Bladder infection _____ Migraines _____ Polio _____

Hernia _____ Blood transfusion _____

Review of Systems: Please place a "YES" if you <u>currently</u> have any of the following:

General
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness
___Depression
___Numbness
___Anxiety
___Tremors
___Sweating

Eyes, Ears, Nose, Throat
___Asthma
___Hearing loss
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Near sighted
___Painful gums
___Hoarseness
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Foot pain
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Ankles
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

Cardiovascular
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

Respiratory
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

Gastrointestinal
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Heartburn / reflux
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

Personal Habits – Please answer honestly. All information is confidential.

Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

	1	2	3	4	5	Please Elaborate
Exercise Regularly (3-4 x week)						
Recreational Drugs						
Drink Alcohol						
Smoke/ Chew tobacco						
Experience Stress						

Family History: Please check off if your relatives have had any of the following diseases.

Relatives	Arthritis	Cancer	Diabetes	Heart Disease/ Stroke	Kidney Disease	Neurological Disease	Thyroid Disease
Father							
Mother							
Brothers/Sisters							
Grandparents							

	Age	**If deceased, cause of death**
Father	_____	_____
Mother	_____	_____
Brothers/Sisters	_____	_____
Children	_____	_____
Spouse	_____	_____

WOMEN ONLY

Are you pregnant or is there any possibility that you are pregnant? Yes No **Date Last Period Began**____/____/____

Do you have regular menstrual cycles? Yes No **Cycle length**_____ **Do you have difficult periods?** Yes No

Age at Menopause (if applicable): _____ **Number of Children Born:** _____ **Have you ever had a Cesarean?** Yes No

Describe Pregnancy Complications (if applicable): _____

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 ina **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

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

Matthew Cusumano, D.O.		
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.

FLORIDA PHYSICAL MEDICINE LLC
POWER OF ATTORNEY & MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RNEDERED, INCLUDING BUT NOT LIMITIED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint FLORIDA PHYSICAL MEDICINE LLC and any of its duly authorized agents and employees as and to be the undersigned's true an lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable for services which have been made by FLORIDA PHYSICAL MEDICINE LLC at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows FLORIDA PHYSICAL MEDICINE, LLC. or any of his agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said FLORIDA PHYSICAL MEDICINE LLC / as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and 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 to release true copies of same to FLORIDA PHYSICAL MEDICINE LLC or any insurer providing coverage to me in connections with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.
The undersigned does hereby ratify and confirm any 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 my insurance company to make medical benefits payments otherwise payable to me for services rendered by any provider at any of Florida Physical Medicine locations, but not to exceed the charges of those services, payable to and mailed directly to:

Dr Matthew Cusumano D.O
FLORIDA PHYSICAL MEDICINE
2200 West Bay Dr., Largo, FL 33770

Furthermore, I hereby IRREVOCABLY ASSIGN to FLORIDA PHYSICAL MEDICINE, LLC. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by FLORIDA PHYSICAL MEDICINE, LLC. I also instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by FLORIDA PHYSICAL MEDICINE, LLC are held in escrow and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned have hereunto set their hand, the _____ day of Month _____, 20_____.

_____ _____
PATIENT SIGNATURE PATIENT PRINTED NAME

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, NOTICE OF PRIVACY & CREDIT CARD GUARANTEE

It is your responsibility to read the following. We will answer any questions to the best of our ability.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. You must notify our insurance department if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Signature_____ Date ____/_____/_____

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Signature_____ Date ____/_____/_____

Video Release Agreement

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that **Florida Physical Medicine** will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in **Florida Physical Medicine** policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

Patient Signature: _____

Witness: _____

Date: _____

FLORIDA PHYSICAL MEDICINE LLC
2200 West Bay Dr. Largo, FL 33770
750 94th Avenue. N., Ste. 202, St. Petersburg, FL 33702
625 6th Avenue. S., Ste. 475, St. Petersburg, FL 33701
(T) 727-518-2977 (F) 727-518-0010

Fax to: _____

Attention: _____

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER: _____

ID NUMBER: _____

NAME OF INSURED: _____

DATE OF ACCIDENT: _____

I, _____, hereby authorize and direct MY INSURANCE COMPANY to send Florida Physical Medicine my coverage information and an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

Signature Patient _____

Patient Name: _____

Date signed _____

To Whom It May Concern,

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

In accordance with Florida Statutes 627.736 (5) (b), I will timely submit all claims to your address with mail documentation.

Truly,
Matthew Cusumano, D.O., Lora Brown, M.D., Adam Di Dio, M.D. & Brad Young R.P.T.

Florida Physical Medicine, LLC.
Phone: 727-518-2977 Fax: 727-518-0010

Letter of Protection and Authorization for Lien on Services

_____ _____
Patient Name Date of Accident

In the event that I, _____ _____, recover money from a settlement of my claim relating to the accident dated above, I direct my attorney to withhold, from my settlement, sufficient funds to pay for all medical care provided by Florida Physical Medicine, LLC, FEIN# 54-2144380, up to the lesser of a.) the funds received from the recovery of the above-named client/patient; or b.) the balance of the account, unless otherwise approved by the legal department.

My attorney will use his/her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement to me is less than the total outstanding charges owed to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, Florida Physical Medicine, LLC. will have priority to have its claim paid first after attorney costs and fees.

My attorney acknowledges independent responsibility to Florida Physical Medicine, LLC. for charges incurred for medical records, medical reports, conferences and witness fees.

In the event that I am not represented by an attorney, I authorize any and all lien holders to pay directly to Florida Physical Medicine all funds due on my account related to the above-named accident.

If I, _____ _____, object to the amount of the bill, I agree that my attorney or any other lien holder to withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the monies withheld, either to the doctor or to me, until a written agreement is made by all parties involved. The only exception would be upon an Order of Court of competent jurisdiction directing that such funds be paid to either me, Florida Physical Medicine, LLC.

By signing below, I have either read or have had explained to me the above written statements. By signing below, I authorize my representing attorney to protect my bills for treatment as outlined above. **I also understand and agree that I am ultimately responsible to Florida Physical Medicine, LLC for the payment of all services rendered for my benefit.**
(a copy will be accepted in place of original)

_____
Name of Representing Attorney

_____ _____ _____ _____
Signature of Client/Patient Date Witness Signature Date

_____ Patient given a copy of LOP/Lien on Services

_____ Patient denied a copy of LOP/Lien on Services

Florida Physical Medicine
2200 West Bay Dr. Largo, FL 33770

DECLINATION OF HEALTH INSURANCE

Florida Physical Medicine does not accept any form of Health Insurance. Treatment provided at our facilities will be billed directly to your auto insurance carrier.

After careful consideration, it is my decision to decline benefits available through my personal or group health insurance.

I understand that by doing so I am waiving any submission of bills from Florida Physical Medicine now, or at ay time in the future to Managed Care, Indemnity, Medicare or Private Network Health Carriers. I am aware that the reason for this is related to properly pre-approving care, timely filing limits of claims and other such industry standards and rules.

I am also fully aware that in the event of an unfavorable judgment of my personal injury matter I am personally responsible for all charges incurred in the office of Florida Physical Medicine.

Date: _____

Name: _____

Signature: _____

OFFICE AND FINANCIAL POLICY

Welcome!

At Florida Physical Medicine we take pride in providing excellent care to our patients.

We ask that our patients notify our office when there is a change of address, phone number or insurance information.

CANCELLATIONS AND NO-SHOW APPOINTMENTS:

It is your responsibility to keep or cancel your appointments. Failure to provide a 24-hour advance notice for a cancelled appointment will result in a $75.00 fee.

INSURANCE

It is the responsibility of the patient to provide the correct auto insurance to Florida Physical Medicine. We will gladly file your insurance claim with your auto insurance in a timely manner to receive payment. If the insurance company does not pay, it will be your responsibility to pay Florida Physical Medicine, LLC for all services rendered on your behalf.

PAYMENT ARRANGEMENTS:

We accept all major credit cards for your convenience.

Please read this policy carefully before signing. Our staff is happy to answer any questions you might have. Your signature certifies that you understand and will comply with this policy.

Patient's Signature: _____ Date: ___/___/___

Controlled Substances Therapy for Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential of abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

_____**(Males Only)** I am aware the chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

_____**(Female Only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ Phone: _____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substance may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with the chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, et. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation.)
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this for voluntarily, I give my consent for the treatment of my pain with controlled substances including but not limited to opioid pain medicines.

_____ _____

Physician Signature Patient Signature

_____ _____

Date Patient Name (Printed)