

SOUTH FLORIDA INJURY CENTERS

5715 N University Dr.

Tamarac, FL 33321

Ph: (954) 606-6325 Fax: (772) 621-5131

**GENERAL RELEASE & RELEASE OF MEDICAL
RECORDS**

TO ALL CONCERNED REGARDING THIS MATTER: That I have requested the release of the X-rays and medical records of:

Print Patient's Name

Patient's DOB: _____ Patient's SS# _____

Dr. Brian S. Wilner

I hereby acknowledge receipt of their X-ray films and medical records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature, or character whatsoever arising from said treatment.

Patient or legal representative's signature

Date

PERSONAL INJURY CONFIDENTIAL PATIENT INFORMATION

South Florida Injury Centers, Inc

5715 N University Dr.,

Tamarac, FL 33321

Date: _____

PLEASE PRINT AND WRITE N/A IF ANYTHING DOES NOT APPLY.

PATIENT DATA

Name: _____ Age: _____ Date of Birth: ___/___/___ Male Female

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

Home #: (____) _____ Cell #: (____) _____ Email _____

Employer: _____ Occupation: _____

Work #: (____) _____ Fax #: (____) _____ Social Security #: _____ - _____ - _____

Driver's License #: _____ Marital Status: Married Single

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Phone #: (____) _____

Name of nearest local relative or friend not living with you: _____

Home #: (____) _____ Work #: _____

PRESENT COMPLAINT

Describe your problem: _____

Other doctor(s) seen for this problem? Yes No (IF YES, GIVE DOCTOR'S NAME):

Were you taken to the hospital? Yes No (IF YES, PROVIDE NAME OF HOSPITAL): _____

Have you missed any work? Yes No (IF YES, PROVIDE DATES MISSED FROM WORK): _____

MEDICAL HISTORY

- | | | | |
|---------------------------------|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> POLIO | <input type="checkbox"/> DIABETES | <input type="checkbox"/> RHEUMATISM | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> DIGESTIVE DISORDER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE |

CANCER DIZZINESS NERVOUSNESS EPILEPSY
 NEURITIS NUMBNESS SINUS TROUBLE HEART TROUBLE
 BACKACHES OTHER: _____

Have you had any surgeries? Yes No (IF YES, LIST TYPE OF SURGERY): _____

Do you drink alcohol? Yes No

Do you smoke cigarettes? Yes No

Treated by a physician for any condition in the last 12 months? Yes No (IF YES, DESCRIBE CONDITION):

Date of last physical exam: ____/____/____ Date of last menstrual period: ____/____/____

Are you pregnant? Yes No

Name of Physician _____ Phone number _____

Allergic to any medication? Yes No (IF YES, WHAT KIND): _____

Taking any medication? Yes No (IF YES, WHAT KIND): _____

ACCIDENTAL INJURY REPORT

Please write N/A if required field does not apply to your case

AUTO ACCIDENT – PLEASE COMPLETE FOLLOWING QUESTIONS:

Date of accident: ____/____/____ Did you report the accident to the insurance company? Yes No

What kinds of vehicles were involved? Truck Car Motorcycle

Were you a: Driver Passenger Pedestrian

IF YOU WERE A PASSENGER PLEASE INDICATE YOUR LOCATION IN THE VEHICLE:

Was your vehicle moving when the accident occurred? Yes No MPH: _____

Did your vehicle hit other vehicles? Yes No Where? _____

Did the other vehicle hit your vehicle? Yes No Where? _____

Was the accident reported to the police department? Yes No

Were traffic citations issued? Yes No To whom? _____

Describe the accident including causes and surrounding/circumstances: _____

**SOUTH FLORIDA INJURY CENTERS, INC.
CONSENT TO MEDICAL CARE**

5715 N University Dr.
Tamarac, FL 33321

PLEASE READ THIS FORM CAREFULLY & COMPLETELY BEFORE SIGNING

I, _____, understand that I have a condition that requires medical treatment. I authorize the Doctor(s) of SOUTH FLORIDA INJURY CENTERS, INC. to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include x-rays, pathological testing, diagnostic testing, or other testing. I understand that if my doctor advises a more complex test, or one, which has special risks, that it will be explained to me. Further, I authorize the personnel of SOUTH FLORIDA INJURY CENTERS, INC. to assist in giving, or to give, the tests, which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health.

Additionally, I authorize the personnel of SOUTH FLORIDA INJURY CENTERS, INC. to assist in the giving, or to give, the therapy, which my doctor may order. I fully understand that medical tests or treatments may involve certain unavoidable risks, if part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment, which I might receive. However, I acknowledge that my doctor is available to answer any questions I might have.

FOR FEMALES OF CHILD BEARING AGE: I certify that to my knowledge I am not, or could be, pregnant and failure to disclose this condition could result in harm to my unborn child if exposed to radiation through x-ray. Therefore, I consent to any diagnostic x-rays that my doctor would need to diagnose my condition and enable him/her to render treatment.

I certify that I have read this form and have had it explained to me. I further certify that I fully understand its contents.

Signature

Date

Witness

FOR PATIENTS UNABLE TO SIGN OR MINORS

Legal Representative

Relationship

Date

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: (please initial each)

- | | | |
|--|---|------------------------------|
| <input type="checkbox"/> Spinal Manipulative therapy | <input type="checkbox"/> Palpation | <input type="checkbox"/> EMS |
| <input type="checkbox"/> Range of motion testing | <input type="checkbox"/> Orthopedic testing | |
| <input type="checkbox"/> Muscle strength testing | <input type="checkbox"/> Postural Analysis | |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Hot/Cold therapy | |
| <input type="checkbox"/> Radiographic studies | <input type="checkbox"/> Vital signs | |
| <input type="checkbox"/> Other (please explain) | <input type="checkbox"/> Basic neurological testing | |
-
-

The material risks inherent in chiropractic adjustment.

As with healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

INFORMED CONSENT DOCUMENT

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOACK AND SIGN BELOW

I have read () or have had read to me () the explanation of the chiropractic adjustment and related treatment. I have had discussed it with Dr. Wilner and have had my questions answered to my satisfaction. By signing below I state 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 informed of the risks, I hereby give my consent to that treatment.

Date: _____

Date: _____

Patient's Printed Name

Doctor's Name

Patient's Signature

Doctor's Signature

SOUTH FLORIDA INJURY CENTERS, Inc.
5715 N University Dr.
Tamarac, FL 33321

AUTHORIZATION TO PAY DOCTOR

I hereby authorize [REDACTED] (insurance company) to pay by check made out and mailed to:

South Florida Injury Centers, Inc.
291 E. Commercial Blvd.
Oakland Park, FL 33334

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charged over and above this insurance payment.

Date

Patient's printed name

Patient's signature

SOUTH FLORIDA INJURY CENTERS, INC.

5715 N University Dr.
Tamarac, FL 33321

HARDSHIP AGREEMENT

Date: _____

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Patient's printed name: _____

Patient's signature: _____

Witness' signature: _____

SOUTH FLORIDA INJURY CENTERS, Inc.
5715 N University Dr.
Tamarac, FL 33321

AUTHORIZATION OF SIGNATURE

I, [REDACTED] hereby authorize Dr. Brian S. Wilner to affix my signature for endorsement of checks made payable to me and Dr. Brian S. Wilner for Chiropractic payment.

Date

Patient's printed name

Patient's signature

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to you records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is April 14, 2004.

Thank you.

HIPAA 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 CAREFULLY.

If you have any questions about the above notice, please contact our office.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature

Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
b. EMPLOYER'S NAME OR SCHOOL NAME		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
c. INSURANCE PLAN NAME OR PROGRAM NAME		SIGNED _____ DATE _____ SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17b. NPI _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)		23. PRIOR AUTHORIZATION NUMBER _____	
1. _____ 3. _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
2. _____ 4. _____		1	
		2	
		3	
		4	
		5	
		6	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____	
29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH. # ()	
a. NPI _____ b. _____		a. NPI _____ b. _____	

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

REVIEW OF SYSTEMS

Name: _____

Date: _____

General

- Unexplained weight loss Fever Trouble sleeping Weakness
 Unexplained weight gain Chills Recent cold of flu Fatigue NONE

Skin

- Rashes Itching Color changes Lumps Dryness Hair & nail changes NONE

Head

- Headache Head injury/trauma Bumps or areas of tenderness NONE

Eyes

- Visual problems Blurry vision Double vision Wear glasses/contacts Flashing lights
 Specks or spots in vision Pain Glaucoma Itching Redness NONE

Ears

- Decreased hearing Earache / Ear pain Ringling in ears (tinnitus) fluid discharge from ear(s) NONE

Nose

- Stuffiness Itching Nosebleeds fluid discharge Hay fever Sinus pain NONE

Throat

- Toothache Pain with swallowing Sore tongue Bleeding gums Non-healing sores
 Hoarseness Lump in throat Dry mouth NONE

Neck

- Lumps Pain Swollen glands Stiffness NONE

Breasts

- Do you do Self Exams? Yes No Lumps Discharge Are you breast feeding? Yes No NONE

Respiratory

- Coughing (dry or wet, productive) Coughing up blood Shortness of breath Labored breathing
 Sputum/Color _____ Painful breathing Wheezing NONE

Cardiovascular

- Chest pain or discomfort Difficulty breathing when lying down Chest or shoulder/arm pain with physical activity
 Tightness in chest Shortness of breath with activity Sudden awakening from sleep w/shortness or breath
 Palpitations NONE

Gastrointestinal

- Difficulty swallowing Change in bowel habits Yellow eyes or skin Nausea Diarrhea
 Heartburn Rectal bleeding Gas or Bloating Abdominal pain after or during meal
 Change in appetite Constipation Abdominal pain prior to meal NONE

Urinary

- Urinate frequently Blood in urine Yellow eyes or skin Feel like urinating but can't or little
 Change in urinary strength Incontinence Burning with urination NONE

Genital**Male**

- Do you do regular self testicular exams? Yes No
 Sores Pain with sex STDs, if yes which _____ Erectile dysfunction
 Hernia Masses or pain Penile discharge NONE

Female

- Pain with sex STDs, if yes which _____ Vaginal discharge Vaginal dryness Hot flashes NONE

Vascular

- Calf pain when walking Leg cramping NONE

Musculoskeletal

- Muscle or joint pain Back pain Neck pain Stiffness Redness of the joints Trauma Swelling of the joints NONE

Neurological

- Dizziness Weakness Tremors Fainting Numbness Headaches Seizures Tingling NONE

Hematologic

- Bruising easily Bleeding easily NONE

Endocrine

- Heat or cold intolerance Frequent urination Change in appetite Sweating Increase Thirst NONE

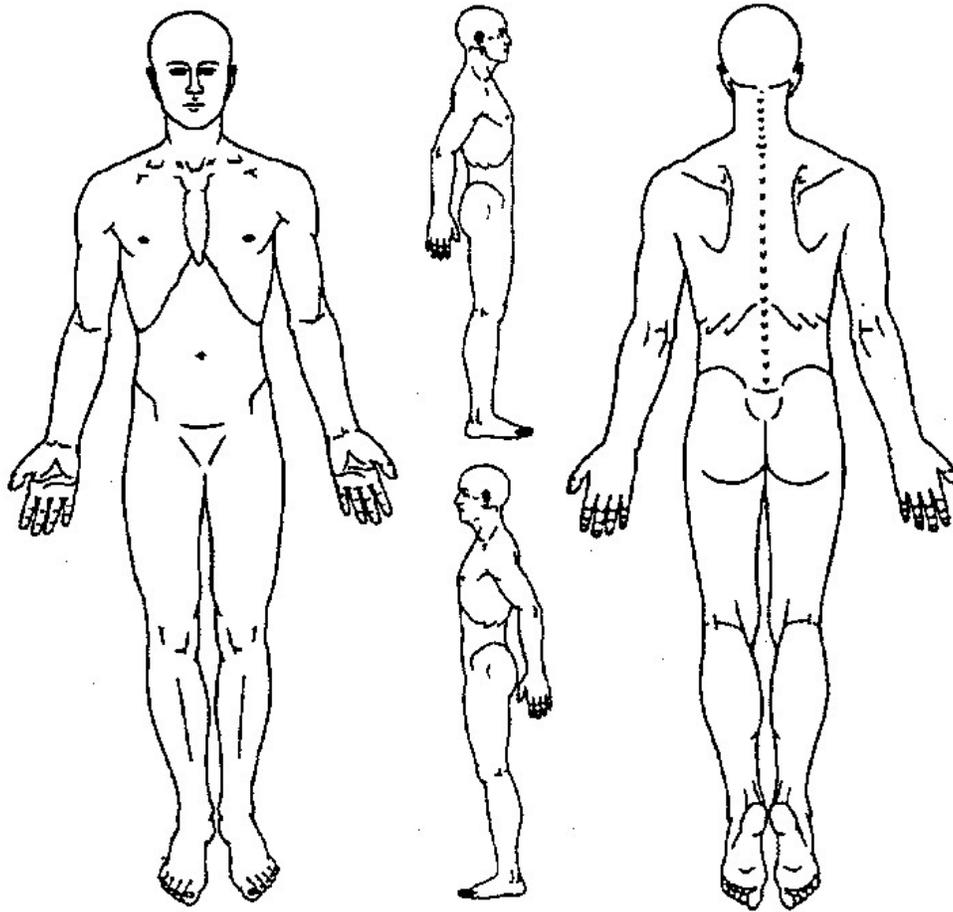
Psychiatric

- Nervousness Memory Loss Stress Depression Anxiety NONE

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

Date: _____ Signature: _____