Multi-Care Medical
OF VERO BEACH

880 37TH PL. UNIT 105 VERO BEACH, FL 32960 PH (772) 617-6795 FX (772)617-6796

DATOS PERSONALES

FECHA: _____/_____/_____ NOMBRE: _____

☐ MASCULINO FECHA DE NACIMIENTO: _____/_____/____ EDAD: _____ SS#: _____

☐ FEMENINO

DIRECCION: _____CIUDAD:_____ESTADO:_____ZIP:_____

CASA #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___ TRABAJO #: ___ ___ ___- ___ ___ ___- ___ ___ ___ ___

CELL #: ___ ___ ___- ___ ___ ___- ____ ____ ____ ___ EMAIL: _____

EMPLEADOR: _____SU POSICION: _____

ESTADO CIVIL: ( ) Menor ( ) Soltero ( ) Casado ( ) Divorciado ( ) Separado ( ) Viudo

NOMBRE DE SU CONYUGE: _____

LA RAZON DE SU VISITA

LA RAZON DE SU VISITA ES POR CONSEQUENCIA DE: __AUTO __ WORK __SPORTS ___TRAUMA

POR FAVOR, EXPLIQUE:

_____

_____

DESCRIBA EL DOLOR Y DONDE LO SIENTE:

_____

_____

CUANDO OCCURIO? _____/_____/_____

SU MALESTAR HA EMPEORADO? ___SI ___NO ____ES CONSTANTE____VA Y VIENE

ESTE MALESTAR ESTA INTERFIRIENDO CON: _____TRABAJO _____DORMIR _____RUTINA DIARIA

HA SUFRIDO ESTA CONDICION O ALGO SIMILAR EN EL PASADO? _____ SI _____ NO

UN MEDICO LO HA TRATADO POR ESTA CONDICION? _____SI _____NO

UN MEDICO LO HA TRATADO POR ESTA CONDICION? ___SI ___NO **QUE MEDICO?**_____

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HISTORIA MEDICA

QUES MEDICAMENTOS ESTA TOMANDO?

☐ Analgesicos ☐ Relajantes de musculos ☐ Estimulantes ☐ Anti-Analgesicos ☐Insulina

HA SUFRIDO ALGUNA DE LAS SIGUIEBNTES ENFERMEDADES O CONDICIONES?

☐Paro Cardiaco/Ataque Cerebral	☐Cirugia del Corazon/Marca Paso	☐Murmullo del Corazon
☐Abuso e drogas/Alcohol	☐Prolapso de la valvula Mitral	☐Valvulas artificales
☐Enfermedad congenital del Corazon	☐Enfermedades Venereas	☐Hepatitis
☐SIDA/HIV	☐Herpes Zoster o Culebrilla	☐Cancer
☐Frecuentes Dolores del Cuello	☐Enfisema/Glaucoma	☐Anemia
☐Presion arterial alta o baja	☐Problemas Siquiatricos	☐Fiebre Reumatica
☐Dolor de Cabeza	☐Problemas Renales	☐Ulceras/ Colitis
☐Desmayos/Epilepsia	☐Problemas de sinusitis	☐Asma
☐Diabetes/ Tuberculosis	☐Dificultad para respirar	☐Quimoterapia
☐Problemas de la espalda	☐Huesos o coyunturas artificiales	☐Ulcers/Colitis

ENUMERE OTRAS CONDICIONES QUE TENGA O HAYA TENIDO:

_____

ENUMERE SUS ALERGIAS:

_____

ENUMERE PREVIAS OPERACIONES/TRATAMIENTOS Y FECHA:

_____

ENUMERE ACIDENTES SERIOS, Y FECHAS:

_____

HISTORIA MEDICA FAMILAR:

_____

FUMA-☐SI☐NO EJERCICIOS-☐SI☐NO DIETA ESPECIAL?☐SI☐NO **PARA MUJERES:**EMBARAZADA? ☐SI☐NO

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DESPUES DE LA LESION

CAYO USTED INCONSIENTE? □SI □NO SI RESPONDIO SI, POR CUANTO TIEMPO? _____

DESCRIBA COMO SE SINTIO IMMEDIATAMENTE DESPUES DEL ACIDENTE:

_____

FUE USTED AL HOSPITAL DESPUES DEL ACIDENTE? □SI □NO

CUANDO FUE? □DESPUES DEL ACIDENTE □AL PROXIMO DIA □DESPUES DE 2 DIAS

COMO LLEGO AL HOSPITAL? □AMBULANCIA □TRANSPORTE PARTICULAR

NOMBRE DEL HOSPITAL? _____

LE TOMARON RADIOGRAFIAS? □SI □NO **LE PRECIBIERON MEDICAMENTOS?** □SI□NO

HA PODIDO TRABAJAR ?□SI □NO

INDIQUE ☑ LOS SINTOMAS QUE HAN RESULTADO DE ESTE ACIDENTE:

□VERTIGO	□INSOMNIO	□PROB DE LA MANDIBULA
□NAUSEAS	□DESMEMORIADO	□IRRITABILIDAD
□DOLOR BRAZOS/HOMBROS	□DOLOR DE ESPALDA	□DOLOR DE CABEZA
□FATIGA	□DEDOS/MANOS INSENSIBLES	□DOLOR DE ESPALDA BAJA
□VISION BORROSA	□TENSION	□DOLOR DE PECHO
□ZUMBIDO EN LOS OIDOS	□DOLOR DE CUELLO	□RESPIRACION CORTA
□DOLOR DE PIERNAS	□TIMBRE EN LOS OIDOS	□CUELLO RIGIDO
□MALESTAR DE ESTOMAGO	□PIES/DEDOS INSNSIBLES	

□OTROS _____

SU CONDICION HA EMPEORADO? □SI □NO □CONSTANTE □VA Y VIENE

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INDIQUE EL NIVEL DE DOLOR CUANDO HACE ALGUNA DE LA SIGUIENTES ACTIVIDADES:

	COMODO	INCOMODO	DOLOROSO
ACOSTADO BOCA ARRIBA	☐	☐	☐
ACOSTADO DE LADO	☐	☐	☐
ACOSTADO BOCA ABAJO	☐	☐	☐
SENTADO	☐	☐	☐
PARADO	☐	☐	☐
ESTIRANDOSE	☐	☐	☐
CAMINANDO	☐	☐	☐
CORRIENDO	☐	☐	☐
DEPORTES	☐	☐	☐
TRABAJANDO	☐	☐	☐
LEVANTANDO ALGO	☐	☐	☐

PARA PODER EVALUAR EL EFECTO QUE REGRESAR A SU TRABAJO LE CAUSARIA A SU RECUPERACION, POR FAVOR RESPONDA A ESTAS PREGUNATAS:

☐ESTA DE PIE ☐CONDUCE ☐USA MAQUINARIA ☐ESTA SENTADO
☐GIRA SU CUERPO ☐TRABAJA CON LAS MANOS ELEVADAS ☐CAMINA
☐LEVANTA ☐ESCRIBE A MAQUINA ☐AGACHADO
☐OTROS_____

- Cuantas horas al dia trabaja? _____
- Antes de lesionarse, podia usted trabajar igual que otras personas de su edad? ___S ___N
- Trabaja con personas que puedan ayudarle levanter cosas pesadas? ___S ___N
- Mientras se recupera, hay algun trabajo suave que pueda usted solicitar? ___S ___N

Autorizo al personal a realizer cualquier servicio necesario durante el diagnostic y tratamiento. Ademas, autorizo al proveedor, o otra agencia de salud, suplir cualquier informacion requerida para rocesar el seguro. Tengo pleno conocimiento de la informacion anterior y garantizo que es complete y correcta en mi entender. Entiendo que es mi responsabilidad informar a esta oficina de cualquier cambio en mi estado medico.

Firma: _____Fecha: _____

Multi-Care Medical
OF VERO BEACH

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to **Multi-Care Medical of Vero Beach**. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow **Multi-Care Medical of Vero Beach** to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify **Multi-Care Medical of Vero Beach** in writing within five days of receipt of this document. Failure to inform **Multi-Care Medical of Vero Beach** shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to **Multi-Care Medical of Vero Beach** and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then **Multi-Care Medical of Vero Beach** is directed to mail the patient/name insured a check, which represents the difference between the medical bills and the premiums paid.

DISPUTES: The insurer is directed by **Multi-Care Medical of Vero Beach** and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and **Multi-Care Medical of Vero Beach** hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by **Multi-Care Medical of Vero Beach** shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accords, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The pay claims at 200% of Medicare then the insurer is instructed & directed to provide **Multi-Care Medical of Vero Beach** with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. 673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination r examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to **Multi-Care Medical of Vero Beach**. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, copayments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. **Multi-Care Medical of Vero Beach** is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I authorize **Multi-Care Medical of Vero Beach** to: furnish an insurer, an insurer's intermediary, the patient's other medical providers and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. **Multi-Care Medical of Vero Beach** is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from **Multi-Care Medical of Vero Beach** and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If the insurer receives a bill from this provider and claim from anyone else on the same day then the insurer is direct to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing **Multi-Care Medical of Vero Beach** of any dispute.

I authorize **Multi-Care Medical of Vero Beach** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that **Multi-Care Medical of Vero Beach** be given a Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to results that may be obtained by any treatment or service; and I agree the provider's treatment and supplies are medically necessary and pertaining to my injuries. **Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient Name: _____ Patient Signature: _____ Date: _____

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PHYSICIAN'S LIEN

To: Attorney_____

Re: Patient: _____ Date of Accident: _____

I hereby authorize the above doctor for furnish you, my attorney, with a full report of his examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to **Multi Care Medical of SW Florida** such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due office and withhold such sums from any settlement, judgment or verdict as may be necessary adequately to pay said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds from any settlement, judgment or verdict which may be paid to you, my attorney or myself a result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee.

Dated: _____ Patient's Signature_____

Address _____

The undersigned being attorney of record for the above patient does hereby agree to

Observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Dated: _____ Attorney Signature: _____

Attorney, please sign and return to doctor's office as soon as possible. Keep one copy for your records.

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical of SW Florida** and/or the physicians of **Multi Care Medical of SW Florida, PLLC** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above-named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi Care Medical of SW Florida** and/or the physicians of **Multi Care Medical of SW Florida**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Date: _____ Signed: _____

Witness: _____ Patient's Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ____ Self ____Other ____________________

Signature: ______________________________Date: _______

OFFICE USE ONLY

WITNESS: ______________________________