1683 Forum Pl
West Palm Beach, FL 33401
Phone: (561) 867-8789
marina@h2tpt.com

Chiropractic H2T PT Physical Therapy

1875 NE 163rd St
North Miami Beach, FL 33162
Phone (786) 786-9986
marina@h2tpt.com

PATIENT NAME: _____ **DATE:**_____

1. **Please check how your current problem began:**
   □ Suddenly □ Gradually □ Bending □ Standing □ Walking □ Lifting □ Sitting □ Pulling
   □ Twisting □ Fall □ Motor Vehicle Accident □ Work Comp Injury ____ Other

2. **In detail please describe how the injury / accident or chronic condition occurred:** _____
   _____
   _____
   _____

3. **Are your symptoms mostly in the:** □ Back □ Leg □ Hip □ Knee □Ankle □ Neck □ Arm
   □ Shoulder □ Elbow □ Wrist □ Other _____
   Do you have any radiating pain in the arm or leg? □ Yes □ No
   Where does it go: □ arm (L or R) □ leg (L or R) □ hands (L or R) □ feet (L or R)
   Any numbness or tingling in arm or leg? □ Yes □ No Where? _____
   Any weakness in arm or leg? □ Yes □ No Where? _____
   Does the pain keep you up at night? □ Yes □ No

4. **How long have you had these symptoms?**
   □ < **2** months □ **2-6** months □ **6-12** months □ > **1** year
   The pain is: □ Constant □ Comes and goes ____ Other
   What makes the pain better: □ Rest □ Ice □ Heat □ Medication □ Changing Positions
   □ Lying Down □ Sitting □ Standing □ Other: _____
   What makes the pain worse? □ Sitting □ Standing □ Walking □ Lifting
   □ Turning your head to the left □ Turning your head to the right □ Looking up/down
   □ Bending Backward □ Bending Forward □ During Exercise □ After Exercise
   □ Pulling □ Pushing □ Lying Down □ Squatting Other: _____

Previous Treatment & Tests:

Did you see another physician for this problem? □ Yes □ No **If yes who (list all)**: _____
_____

What medications have you taken for this problem?
□ muscle relaxant □ pain medication
□ anti-inflammatory (prescription or over the counter) □ Other: _____

What tests have you had? □ CT Scan □MRI □X-ray □EMG □ Other _____

Did you receive physical therapy / chiropractic treatment? □ Yes □ No
Did the treatments improve your symptoms? □ Yes □ No

Did you have any injections for this problem?
□ Epidural Steroid Inj. □ Facet Inj. □ Trigger Point Inj. □ Radiofrequency
□ Medial Branch Block □ Sacro-Iliac Inj.

Did you have previous surgery for this problem? □ Yes □ No
If yes, please describe: _____
_____
_____

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Past Medical History:

List any other PREVIOUS SURGERIES you have had and the dates:

_____
_____
_____
_____

Past Medical History:

List all pre-existing medical conditions you are aware of, including but not limited to any prior injuries to the area(s) of you body for which you are seeking treatment here: _____

_____
_____
_____.

Please list ANY and ALL MEDICATIONS you are currently taking (including over the counter, vitamins, and herbal medication)

MEDICATION NAME	DOSAGE	FREQUENCY

Do you have any ALLERGIES to medication? □ NO KNOWN DRUG ALLERGIES
If yes list any *ALLERGIES* you have to food, medications, and type of reaction:

_____
_____
_____

Social History:

Do you smoke? □ No □ Yes
If so: □ Daily □ Weekly □ Monthly and how many?_____Cigarettes/day_____Packs/day
Do you drink alcohol? □ No □ Yes
If so: □ Daily □ Weekly □ Monthly and how much _____
Are you working? □ No □ Yes
If so what is your Occupation**:** _____
Does your current complaint affect your ability to work? □ No □ Yes
If so how does it limit you: _____
_____
_____
_____
_____

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Review of Systems:

Do you currently have or have had problems with any of the following:
If yes please describe next to issue.

Problem	NO	YES	PLEASE EXPLAIN BELOW
Skin			
Ears / Nose / Throat			
Cardiac/High blood pressure			
Lungs, (Asthma, Infection)			
Stomach / Digestion			
Bladder / Bowel problems			
Hematologic / Bleeding disorders			
Diabetes			
Cancer			
Musculoskeletal			
Neurological			
Psychiatric problems			
Reproductive / Sexual Problems			
Migraines / headaches			
Anxiety/Depression			
Fever / chills			
Weight loss			
Night sweats			
HIV/AIDS			

ADD BOXES FOR THE FOLLOWING: NECK, MID BACK, LOW BACK, TOES, ANKLES, KNEES, HIPS, SHOULDERS, ELBOWS, WRISTS, FINGERS

Family History:

Do any of your family members have a history of:

Problem	NO	YES
Anxiety/Depression		
Arthritis or joint pain		
Diabetes		
Hypertension		
Heart problems		
Thyroid problems		
Psychiatric problems		
Bleeding disorders		
Cancer		
Epilepsy		
Adverse Reaction to Anesthesia		

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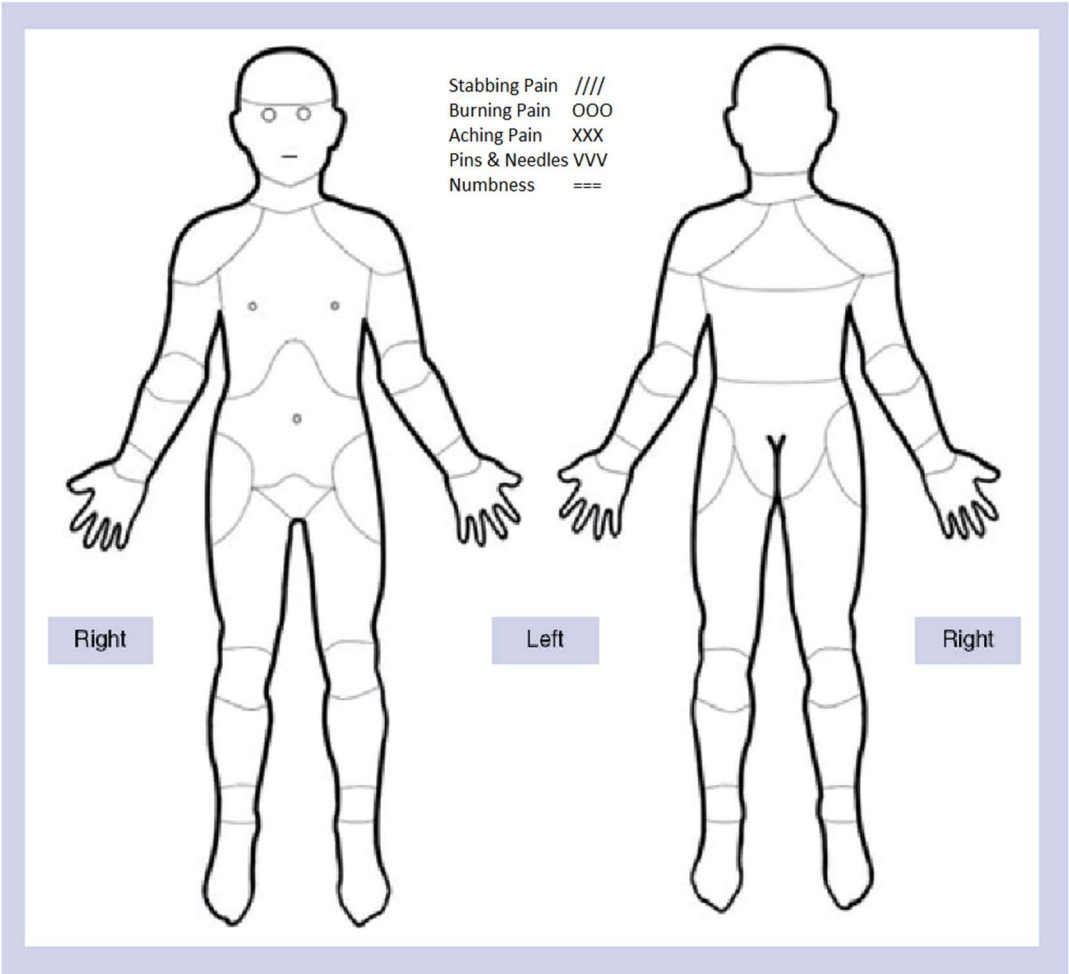
Where is your pain now?

Please indicate in the table below the percentage of pain that you have on average in the appropriate body part and mark the corresponding pain on the body: **Total percentage=100%**

Neck	%	L	R	Shoulder	%	L	R
Back	%	L	R	Hip	%	L	R
Leg	%	L	R	Arm	%	L	R
Knee	%	L	R	Elbow	%	L	R
Ankle	%	L	R	Wrist	%	L	R



Please mark an "X" on the face that most accurately describes your overall degree of pain.

Wong-Baker FACES™ Pain Rating Scale

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We wish to maintain current and comprehensive information applicable to your treatment at our facility; therefore, please indicate below if you have health insurance coverage. Thank you.

❑ Yes, I have health insurance.

Primary Insurance

Name of Carrier _____

Policy Number _____

Secondary Insurance

If yes, Name of Carrier _____

Policy Number _____

❑ No, I do not have health insurance.

Important
Please present insurance cards to the
Front Office Staff. Thank you.

Signature _____ Date _____

Print Name: _____

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Patient Information

First Name:	Middle Initial:	Last Name:	Gender: ☐Male ☐Female
Street Address:	Apt #:	City:	State, Zip:
Date of Birth: / /	SSN: - -	Marital Status: ☐Married ☐Single ☐Divorced ☐Partnered ☐Widowed	
Home Phone:	Cell Phone:	May we web enable the patient portal? (Required)	
E-mail Address (Required):			
What is your preferred method of contact? ☐ Home Phone ☐Cell Phone ☐E-mail ☐Mail			
Occupation: ☐ Full time ☐Part time ☐Self Employed ☐Not Employed ☐ Retired			
Emergency Contact:	Contact Phone:	Relationship to Patient: ☐Spouse ☐Child ☐Sibling ☐Parent ☐Friend	
Do you have an Advanced Directive or Living Will? ☐Yes (Please provide a copy for office records.) ☐No			
Race ☐White ☐ Black or African American ☐Hispanic Asian ☐ Pacific Island ☐ American Indian ☐Other race:_____ ☐Unreported/ Refuse to Report			
Preferred Language:	Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐ Unreported/ Refused to Report		
Please provide your pharmacy name as required by law:	**Phone:** **Zip:**		

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Consent for Treatment and Assignment of Benefits

_____(Initials) I, the referenced or undersigned patient, agree that the above-named healthcare company/entity with which I am hereby contracting, does not owe me a non-delegable duty to provide me with non-negligent healthcare. Therefore, I agree that as to any claim that I may have or acquire concerning or involving my healthcare that includes, in whole or part, a claim of liability for negligent or deficient conduct (whether by act or omission), I hereby release the aforesaid healthcare company/entity and its employees, officers, members, and managers from any and all liability, and will look solely to the individual doctor or physician who treats me, or operates on me, for any and all claims of liability or damages.

_____(Initials) I hereby voluntarily consent to the rendering of care and treatment, and I understand that I am under the care and supervision of physicians/providers of H2T PT, LLC and it is my responsibility to carry out instructions of my physicians/providers.

Consent for treatment of a minor

_____(Initials) I understand that the patient named above may be suffering from a condition that requires diagnosis and medical treatment which may require further testing and clinical evaluation. With full understanding of all the forgoing, I do hereby consent to and authorize the performance upon the patient of clinical evaluation and diagnostic and therapeutic procedure(s) as ordered by H2T PT, LLC .

Name of Minor: _____
Parent or Guardian Signature: _____

Financial Agreement

_____(Initials) In addition to all other agreements I have or come to have with this healthcare provider, I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians and healthcare providers for services rendered. I understand that I am financially responsible for paying the full amount all charges whether or not they are covered by insurance. In the event I do not pay the full amount of all charges, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be valid as an original.

_____(Initials) If health insurance is going to be used as a pay source, then Insurance authorization must be obtained before a patient is seen. If I do not inform the healthcare providers here who see or treat me, of my current insurance or the insurance is denied because of no authorization, I agree that I will remain responsible for payment in full of all billed charges. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see a healthcare provider here, I will be responsible for the entire bill at the time of service. Notwithstanding anything hereinabove, I authorize the healthcare providers here not to bill my health insurance for any services provided to me, at the election of the healthcare providers.

_____(Initials) I have received or been given the opportunity to receive a copy of your Notice of Privacy Practices.

Patient Signature: _____

Or ***Responsible party Signature:*** _____

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ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and my attorney(s), jointly and severally, to pay directly to H2T PT, LLC (referred to herein as "Provider" or "Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills issued by Assignee, and to withhold such sums from any disability benefits, medical payments, or any other health or liability insurance benefits in which I may have or acquire a right or interest in any respect, as may be necessary to fully satisfy the charges of said Assignee. With regard to submitting for no-fault ("PIP") benefits or reimbursement for services personally rendered by a Physician or other healthcare provider who may be an employee or contractor of Provider, I hereby assign to such individual physician(s) or other healthcare provider(s) who render any services to me all rights and benefits I may have, or come to have, under any Personal Injury Protection / No-Fault Insurance ("PIP"), including the right to submit to any such PIP carrier directly for reimbursement bills for services rendered to me. Said assignment by me is not a delegation of any duties that I may have under any such PIP insurance. Further, should any or all such physicians or healthcare providers authorize Provider, in any manner, to bill, receive, or process any PIP payments I have hereby assigned for the benefit of any or all such physicians or other healthcare providers, then in that event Provider shall be considered merely a billing agent of or clearinghouse for such physicians or other healthcare providers, regardless of whether any such billings for PIP reimbursements or benefits may appear to be in the name of Provider (and as such, Provider shall be acting merely as an agent of/for said physicians and other healthcare providers, rather than billing or submitting for PIP reimbursements or benefits in its own or right). To supplement this process I specifically give and grant to Provider a power of attorney rendering Spine my attorney-in-fact to act as my agent to facilitate any/all such physicians' and other healthcare providers' individual rights and efforts to process all applications for payment and receipt of payment of PIP benefits or reimbursements in the name and under the EIN of any such physician or other healthcare provider or his/her practice entity, or in the name and under the EIN of Provider as the billing agent or clearinghouse for any/all such physicians or other healthcare providers, at Provider's election, with all PIP payments received to be posted to the given Physician's or other healthcare provider's account as revenue of said physician or other healthcare provider. This power of attorney granted to Provider by me herein is a grant coupled with an interest, is irrevocable, and shall survive the end of services rendered to me for a period of sixty (60) months. Whether I do or do not have insurance coverage or may have any rights under any insurance policy (including a liability policy upon which I may have or come to have the right to make a claim), I understand that I am and shall remain personally responsible for payment in full of all bills for services rendered by the Assignee and healthcare providers who may be employees or contractors of Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided, but not a delegation of any duties I may have under or regarding any benefits I have or hereby assign. In the event that any insurance company that may be obligated to make payment to me upon or concerning charges made by the Assignee or healthcare providers who may be employees or contractors of Assignee for services rendered to me, either delays or refuses to make such payment upon such cause of action that I might have or that might exist in my favor against such company, I authorize Assignee and healthcare providers who may be employees or contractors of Assignee to prosecute said cause of action either in my name or Assignee's, and I further authorize Assignee to compromise, settle, or otherwise resolve said claim or cause of action as Assignee sees fit.

Direction of Payment

I hereby authorize and instruct any insurance company, attorney, and all other agents or representatives of mine to pay in full directly to Assignee the amount of all bills for services rendered to me. Without limitation of any other terms of this agreement or any other agreement with the Assignee, I also agree to pay directly to Assignee in a current manner any difference between the total charges and the amount paid by any insurance company. This agreement and the foregoing power of attorney also allows Assignee to endorse any check or draft provided to Assignee in my name for purposes of payment for services rendered *to* me by Assignee or its employees, contractors, or agents. Assignee is an express beneficiary and a third-party beneficiary of the instructions I have given in this Assignment, and can enforce any or all of said instructions in its own name and right just as if I were the Assignee seeking to enforce said instructions.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case(s) or condition(s), to my insurance company or the attorney Involved in any such case(s), pursuant to Section 627.4137, Florida Statutes. I hereby request that a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of or any other accident in which I may be involved, be provided to this Assignee upon each and every request of said Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as Assignee deems necessary. If any term or provision of this Assignment and Authorization or the application thereof to any person or circumstance shall, to any extent, be determined to be invalid or unenforceable, the remainder of this Assignment and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment and Authorization shall be valid and enforced to the fullest extent of the law (for example only, as by any physician or other healthcare provider who rendered any service to me, instead of by Spine).

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce, delay, or fail to pay any part of or the entire bill which was submitted on my behalf from this healthcare provider, I (the assignor) as well as the assignee (for itself any and all physicians and other healthcare providers who may be employees or contractors for Provider) are requesting, in advance, that you reserve, or "set-aside," the amount reduced or denied or delayed until the dispute is resolved. Should you submit a check to Provider or any physician or other healthcare provider who may be an employee or contractor of Provider which is less than the correct amount, and it contains any language referring to or purporting to declare payment(s) as "Full and Final Payment," or the like, then I have instructed assignee to return the check to you (the insurer) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, delayed, or failed to pay, please notify me (the assignor) and the assignee in writing immediately.

Patient Name: _____

Signature of patient or guardian: _____

Date: _____

Health Care Provider

H2T PT, LLC
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N.M.B., FL 33162

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I give permission for my medical information / medical notes to be disclosed to and discussed with the following:

√ Primary Care Physician √ Referring Physician √ Attorney Representing Me

√ Auto Insurance/ Health Insurance √ Entity to whom I have been referred in regards to treatment

Other People with whom we can discuss your healthcare:

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

I give permission to release my protected health information to the following entity:

H2T PT, LLC.

Fax Number:
□ WPB (561) 841-6054 □ NMB (786) 789-9880

Patient/Guardian Signature: _____ **Date:** _____