New Patient Information Form

PLEASE PRINT

GENERAL INFORMATION

Patient LAST name: ______________________ FIRST name: ______________________

Address: ________________________________ Care of: ____________________

City: ________________ State: ______ Zip: _______ Phone (H): ______________

DL #: __________________ No. Children: __________ Phone (C): ______________

Out of State Address: ____________________________ Phone: ________________

Spouse's Name: __________ Spouse's Employer: ________ Native Language: __________

Email Address: _______________________________

Sex: M / F   Married / Single / Widowed / Divorced   DOB ____/____/____   SS# ____________

Employer's Name: _______________ **EMPLOYED**: Full Time / Part Time / Retired / Unemployed

Employer's Address: ________________ City: ______________ State: _____ Zip: _______

Phone: ____________ Occupation: ___________ **STUDENT:** Full Time / Part Time / Non-Student

INSURANCE INFORMATION – Commercial Insurance and Medicare **Only**

PRIMARY Insurance Company

____

Type   Group   Private

Membership/Cert #: ______________________

Policy Group #: ______________________

Complete only if Patient is **NOT** the Insured

Insured's Information:
Insured's Name: ________________
M / F Married Single Widowed Divorced
Patient Relation to Insured: __________
Insured's DOB: ____/____/____
Insured's Employer: ______________

SECONDARY Insurance Company

____

Type   Group   Private

Membership/Cert #: ______________________

Policy Group #: ______________________

Complete only if Patient is **NOT** the Insured

Insured's Information:
Insured's Name: ________________
M / F Married Single Widowed Divorced
Patient Relation to Insured: __________
Insured's DOB: ____/____/____
Insured's Employer: ______________

AUTOMOBILE ACCIDENT/ WORKER'S COMPENSATION

Insurance Company: ______________ Claim #: __________________ Policy #: ______________

Address: _________________________ City: _______________ State: ______ Zip: __________

Phone Number: _______________ Date of Injury: ____/____/____

Attorney's Name: ____________________ Phone Number: ________________

Address: _________________________ Contact Name: ________________

Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patients Signature: ______________________________________ Date: ______________

Michael Papa D.C., P.A.
2632 West Indiantown Road
Jupiter, FL 33458
Phone: 561-744-7373 Fax: 561-743-1192

ASSIGNMENT OF BENEFITS

I, the undersigned patient, hereby assign my Personal Injury Protection insurance benefits under my policy of automobile insurance or all other applicable Private policies benefits under my medical insurance, for all causes of actions to **MICHAEL PAPA D.C., P.A.**, its subsidiaries and its agents, including but not limited to **MICHAEL PAPA D.C., P.A.**, for services rendered to the undersigned patient in accordance with Florida Statue 627.736(5), that would otherwise be payable to me for services rendered.

I fully understand that by the execution of this assignment of benefits, that I also grant **MICHAEL PAPA D.C., P.A.**, its subsidiaries and its agents including but not limited to **MICHAEL PAPA D.C., P.A.**, full power of attorney and authority to act in or on my behalf insofar as the endorsing and cashing of checks as well as the execution of any other documents that may be related to this matter or claim. I agree to be fully responsible for the services provided regardless of settlement, judgment or verdict. I further direct my Private insurance carrier to provide any medical provider with an updated copy of the PIP Payment Log. A photocopy of this document shall be as binding as the original signature page.

PATIENTS/INSURED SIGNATURE________________________________

INSURANCE COMPANY____________________________________

DATE____

DATE OF ACCIDENT_____________________________________
(If applicable)

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance. We accept CASH, CHECK, MASTER, DISCOVER, AMERICAN EXPRESS, or VISA CARDS. We will be happy to help you process your insurance claim-form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of **1.5 %** per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however that:

1. You insurance is a contract between you, your employer and the insurance company. We are not a party to contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (50% or 80%) of "U.C.R."
   a. "U.C.R." is defined as usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you and not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE do not hesitate to ask us. We are here to help you.

PATIENTS/INSURED SIGNATURE______________________________

INSURANCE COMPANY______________________________

DATE______________________________

DATE OF ACCIDENT______________________________
(If applicable)

PRIVACY PRACTICES ACKNOWLEDGMENT

Posted on Lobby Wall

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.

NAME ______________________________ BIRTHDATE ________________

SIGNATURE _________________________

DATE _______________

WAIVER

I acknowledge that I was given the opportunity to accept the Notice of Privacy Practices and have chosen not to receive that Notice or have it explained to me.

NAME ______________________________ BIRTHDATE ________________

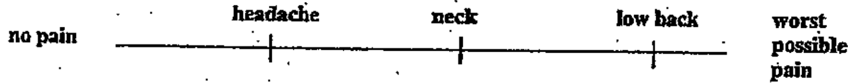
SIGNATURE _____________________________

DATE ________________

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

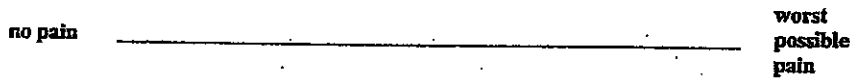


worst possible pain

##

1. What is your pain RIGHT NOW?

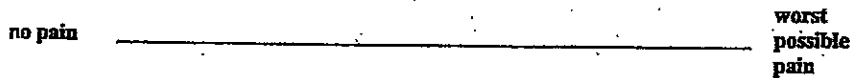
no pain



worst possible pain

2. What is your TYPICAL or AVERAGE pain?

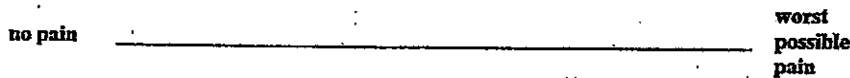
no pain



worst possible pain

3. What is your pain level AT ITS BEST?

no pain



worst possible pain

What percentage of your awake hours is your pain at its best? ________%

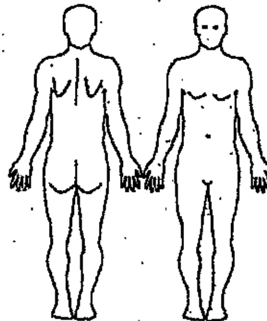
4. What is your pain level AT ITS WORST?

no pain

worst possible pain

What percentage of your awake hours is your pain at its worst? ________%

Mark the diagram as follows:
- **A - Ache**
- **B - Burning**
- **N - Numbness**
- **P - Pins & Needles**
- **S - Stabbing**
- **O - Other - Describe**



NAME____ AGE________ DATE____________ SCORE______

SCORE: #1 ______ + #2 ______ + #4 ______ = ______ / 3 x 10 = ________ (Low intensity = <50; High intensity = >50)

Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373
(561) 743-1192 Fax

RELEASE OF RECORDS

Date: ________________

To: ____
(Doctor or Hospital)

Address: ____

____

I hereby authorize and request you to release my complete medical records, concerning my illness and/or treatment during the period of: _______________ to _____________.

To: Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373
(561) 743-1192 Fax

Name: ____________________________

DOB: ______________________

Date: _________________

Signed: ____
(Signature of patient/guardian, if patient is a minor.)

Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373

X-RAY CONSENT FORM & PREGNANCY RELEASE IF APPLICABLE

Patient Name: ______________________________

Patient Date of Birth: ____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

FEMALE ONLY 1-4

1. Are you pregnant or any chance you may be: YES / NO
2. Date of the start of your last period: ____________
3. Are you on any type of Birth Control? YES / NO
4. Are you trying to get pregnant? : YES / NO

Your signature indicates that you have read, understood and answered all of the above and accept all responsibility associated with exposure to yourself or your unborn child and have accurately answered the above statements.

Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________