**OFFICE USE ONLY**:

**HT\_\_\_\_\_\_\_ WT\_\_\_\_\_\_\_ BP\_\_\_\_\_\_/\_\_\_\_\_\_\_ PULSE\_\_\_\_\_\_\_\_ TEMP \_\_\_\_\_\_\_\_ P/S \_\_\_\_\_\_\_\_**



**ADVANCED WELLNESS & ORTHOPEDICS CENTER**

616 N. PALMETTO STREET

LEESBURG, FL 34748

PHONE: 352-702-0850 FAX: 352-530-2476

EMAIL: INFO@ADVANCEDWELLNESSORTHOPEDICS.COM

**PRIMARY CARE PATIENT FORM**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL ADDRESS (IF DIFFERENT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: (circle one) S M D

MALE: FEMALE: EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW WOULD YOU LIKE TO BE REMINDED ABOUT UPCOMING APPTS: EMAIL TEXT PHONE CALL

DO YOU HAVE A PRIMANY CARE PHYSICIAN? YES OR NO DRS. NAME & PH#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYED: YES NO EMPLOYER’S NAME & PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:**

NAME OF INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER’S NAME & DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(SUSCRIBER’S NAME)

POLICY/MEMBER ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU HAVE MEDICARE, CHOOSE THE TYPE: **STANDARD MEDICARE MEDICARES SUPPLEMENT**

**MEDICARE ADVANTAGE PLAN**

POLICY ID/MEMBER # FOR MEDICARE SUPPLEMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(IF APPLICABLE)

NAME OF SECONDARY INSURANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY/MEMBER # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(IF APPLICABLE)

SUBSCRIBER’S NAME & DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



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**PRIMARY CARE PATIENT FORM**

**MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LATEX ALLERGY: YES OR NO FOOD ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS YOU'RE CURRENTLY TAKING. PLEASE WRITE N/A

IF YOU TAKE NO MEDICATIONS OF ANY KIND OR ATTACH A SEPARATE SHEET, IF NEEDED.

|  |  |  |
| --- | --- | --- |
| NAME OF MEDICATION | DOSAGE/STRENGTH | FREQUENCY OR HOW OFTEN YOU TAKE IT (I.E. DAILY, TWICE A DAY, ONCE A WEEK, ETC) |
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LIST ALL HOSPITILIZATIONS AND/OR SURGERIES YOU’VE HAD AND APPROXIMATELY WHEN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT PHARMACY DO YOU USE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT CITY OR LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**ADVANCED WELLNESS & ORTHOPEDIC CENTER**

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LEESBURG, FL 34748

PHONE: 352-702-0850 FAX: 352-530-2476

EMAIL: [INFO@ADVANCEDWELLNESSORTHOPEDICS.COM](mailto:INFO@ADVANCEDWELLNESSORTHOPEDICS.COM)

**PRIMARY CARE PATIENT FORM**

**REASON FOR TODAY’S VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CHECK ALL THAT APPLY:**

* **LUNG ISSUES**
* **COUGH**
* **SEASONAL ALLERGIES**
* **NEUROLOGICAL PROBLEMS**
* **SEIZURES**
* **JOINT PAIN**
* **KIDNEY/BLADDER ISSUES**
* **LIVER PROBLEMS (HEPATITIS)**
* **THYROID ISSUES**
* **EYE DISORDERS**
* **CHRONIC HEADACHES**
* **DERMATOLOGICAL PROBLEMS**
* **CHEST PAIN**
* **SLEEP DISORDERS/FATIGUE**
* **HEART ARHYTHMIAS/MURMUR’S**
* **HEART BURN (REFULX/GERD)**
* **HIGH BLOOD PRESSURE/HYPERTENSION**
* **ANEMIA OR BLOOD DEFICIENCY**
* **EAR/NOSE/THROAT PROBLEMS**
* **ARTHRITIS**
* **ULCERS/COLITIS/CROHN’S**
* **GYN PROBLEMS**
* **DEPRESSION AND/OR ANXIETY**
* **HEART DISEASE**
* **HEART ATTACK/STROKE & WHEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **CANCER: WHEN AND WHAT TYPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IN REMISSION: YES OR NO**
* **DIABETES- HOW LONG? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHAT TYPE: TYPE I TYPE 2 GESTATIONAL**

**LAST MAMMOGRAM-DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST PAP-DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU DRINK? YES NO HOW OFTEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU SMOKE? YES NO YES, BUT NO LONGER SMOKE**

**PACKS OR # PER DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FOR HOW MANY YEARS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ADVANCED WELLNESS & ORTHOPEDIC CENTER INSURANCE ASSIGNMENT & AUTHORIZATION FORM**

**PRIMARY CARE PATIENT FORM**

For good and valuable consideration, including the agreement of **Advanced Rehab Specialties, PA,**

**d/b/a Advanced Wellness & Orthopedic Center** to accept this assignment in lieu of demanding full payment of services from the undersigned on all dates in which services are rendered. The undersigned patient executed this document hereby assigning **Advanced Wellness & Orthopedic Center** the right to receive insurance benefits directly from any Insurance Company that is obligated to provide medical insurance benefits, either to me or on my behalf, for services rendered by **Advanced Wellness & Orthopedic Center.**

All Insurance Companies obligated to pay insurance benefits to me, or on my behalf, relating to the above accident/injury for services provided by **Advanced Rehab Specialties, PA, d/b/a Advanced Wellness & Orthopedic Center** are here by directed to issue payment/s for those benefits directly to **Advanced Rehab Specialties, PA.**

I authorize and assign to **Advanced Rehab Specialties, PA** the right to file suit and pursue all legal actions to obtain payment for services rendered and provided to me by **Advanced Rehab Specialties, PA**. The authorization to file is an assignment of action to obtain payment for services provided to me by **Advanced Rehab Specialties, PA** and includes the assignment to pursue declaratory relief or any other legal remedies.

**Advanced Rehab Specialties, PA** accepts the aforesaid assignment and hereby notifies the Insurance Company issuing payment its objection to any "re-pricing", "down-coding" or "reductions" of billed amounts submitted and any such reduced payments are issued are accepted under protest and without waiving any right to the provider to pursue all legal remedies and actions.

I authorize the release of any information concerning my healthcare treatment provided to me to the Insurance Company to determine all benefits payable. By signing below you are stating that you fully understand this document and, you agree to the terms set forth.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



HIPPA NOTICE OF PRIVACY  
ADVANCED REHAB SPECIALTIES, P.A.

D/B/A AVANCED WELLNESS & ORTHOPEDICS CENTER

PHONE: 352-702-0850 FAX: 352-530-2476

EMAIL:INFO@ADVANCEDWELLNESSORTHOPEDICS.COM

**HIPPA COMPLIANCE OFFICER - PLEASE CALL 352-702-0850**

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practice with the respect to Protect Health Information. We are required to maintain the privacy of and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPPA COMPLIANCE OFFICER in person or by phone at the number listed above.

I authorize Advanced Wellness & Orthopedic Center to release my PHI (Protected Health Information) to the following person/persons:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

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I have read and understand the disclosure and agree to it. I understand that I can obtain a copy at any time either electronically or printed upon request.

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WITNESS OR EMPLOYEE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(PRINT NAME)**

**WITNESS OR EMPLOYEE’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADVANCED WELLNESS & ORTHOPEDICS CENTER**

**CONSENT FORM**

**PLEASE INITIAL BEFORE EACH PARAGRAPH**

\_\_\_\_\_\_\_\_\_\_\_I understand that as a part of my healthcare Advanced Rehab Specialties, PA originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care and treatment. I also understand this information serves as:

* A basis for planning my care and treatment
* A means of communicating among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third party payer can verify that services billed were actually provided
* A tool for routine health care operations such as assessing quality reviewing the competence of the healthcare professional

\_\_\_\_\_\_\_\_\_\_\_\_I understand and have been provided with a Notice of Information Practices that provide a more complex description of the information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices, and prior to implementation, will be mailed a copy of the revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that practice has already taken action in the reliance thereon. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

\_\_\_\_\_\_\_\_\_\_\_\_With this consent, Advanced Wellness & Orthopedic Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and call pertaining to my clinical care, including laboratory results among others.

\_\_\_\_\_\_\_\_\_\_\_\_With this consent, Advanced Wellness & Orthopedic Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marker Personal and Confidential.

\_\_\_\_\_\_\_\_\_\_\_\_With this consent, Advanced Wellness & Orthopedic Center may e-mail to me my appointment reminders and patient statements. I have the right to request that Advanced Rehab Specialties, PA restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to the requested restrictions, but if it does, it is bound by this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_By signing this form, I am consenting to Advanced Wellness Rehab Specialties, PA to use and disclose my PHI to carry out TPO.

\_\_\_\_\_\_\_\_\_\_\_\_I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Advanced Rehab Specialties, PA will decline treatment to me.

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Advanced Wellness & Orthopedic Center – FINANCIAL RESPONSIBILITY**

**\_\_FINANCIALPOLICY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

**APPOINTMENTS**

**1: Co-payments:** Co-payments for the office visits are due at the time of service. If you are unable to make your co-payment at the time of service, Advanced Wellness & Orthopedic Center reserves the right to reschedule your appointment until a time that you are able to make your co-payment. Payment for any outstanding balance is due at your appointment.

**2: Procedure Prepayment:** Advance Wellness & Orthopedic Center collects your payment for an office visit at the time of the scheduled visit. Your co-pay is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until any previous balances or co-pays have been made.

**3: Missed Appointments and Late Arrivals:** If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to the appointment, you will be responsible for a missed appointment fee. Missed office visits are subject to a $25 charge. Missed Procedures - **(i.e. - small surgical procedures, facet/epidural injections, cyst removals, etc.)** are subject to a $60-350 charge depending on the type of procedure that was scheduled. These charges are your responsibility and will not be billed to any insurance carrier.

**INSURANCE PAYMENTS**

**4: Financial Responsibility:** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

**5: Coverage Charges and Timely Submission:** It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. There is a time limit which Advanced Wellness & Orthopedic Center must submit a claim on your behalf to your insurer. If Advanced Wellness & Orthopedic Center is unable to submit your claim within this period because we have not been supplied your correct insurance information (this includes Supplemental and Advantage Plans) you will be responsible for the entire amount of the charges. It is the patient’s responsibility to notify us if their insurance changes.

**6: Self- Pay:** Advanced Wellness & Orthopedic Center will see patients who are not insured under a letter of protection from their legal counsel in the setting of personal injury accident; if you do not fall under this category you may be seen under your health care insurance or you may pay cash for your visit. For cash visits please contact the front desk for pricing or if you have healthcare insurance and wish to be seen but out of network, please contact the front desk for further information.

**Advanced Wellness & Orthopedic Center**

**BENEFITS AND AUTHORIZATION**

**7: Insurance Plan Participation:** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have different or higher deductibles and co-payments.

**8: Referrals:** Referral requirements vary widely among insurance carriers and plans and it is extremely hard to track which insurance plans need a referral. If your insurance carrier requires a referral for you to be treated by us then it is your responsibility to be aware of this fact, and to obtain the proper referral, not ours.

**9: Prior Authorization and Non-covered Services:** Advanced Wellness & Orthopedic Center may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Advanced Wellness & Orthopedic Center, as a courtesy to our patients, will make a good faith effort to determine if services we order are covered by your insurance plan. If it is determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf but ultimately it is your responsibility to obtain such authorization.

**10: Out of Network Payments:** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Advanced Wellness & Orthopedic Center immediately.

**ACCOUNT BALANCES AND PAYMENTS**

**11: Reassignment of Balances:** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

**12: Collection of Unpaid Accounts:** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or became delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or attorney, which may result in reporting to the credit bureaus and/or legal action. Advanced Wellness & Orthopedic Center reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Advanced Wellness & Orthopedic Center for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

**13: Returned Checks:** Returned checks will be subject to a $40 returned check fee.

**14: Refunds:** Refunds for overpayment or prepayment on canceled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send to AWOC Billing Services.

**Advanced Wellness & Orthopedic Center**

**15: Statements:** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

**AGREEMENT AND ASSIGNMENT OF BENEFITS**

I have read and understand the financial policy of Advanced Wellness & Orthopedic Center, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Advanced Rehab Specialists dba Advanced Wellness & Orthopedic Center. I understand that I am financially responsible for all services I receive from Advanced Wellness & Orthopedic Center. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_