COASTAL HEALTH | Injury

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Email Address: _____

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Primary Language: _____ Race: _____

Ethnicity: _____ Hispanic or Latino?: ☐ Yes ☐ No

State of Driver's License: _____ Driver's License Number: _____

Primary Care Physician: _____ Referring Physician: _____

Employer's Name & Address: _____ Employer's Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City: _____ State: ____ Zip: _____

If Patient is Married Please Complete this Section:

Spouse's Name: _____ Social Security #: _____ Date of Birth: _____

Spouse's Employer: _____ Employer's Phone: _____

Spouse's Employer's Address: _____ City: _____ State: ____ Zip: _____

Does the patient have health insurance? (Please check one.) ☐ Yes ☐ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: _____

Secondary Insurance Carrier(s): _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Gender: ☐ M ☐ F Subscriber Social Security #: _____ Subscriber I.D. #: _____

Subscriber's relationship to patient (mother, father, grandmother, etc.): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Cell: _____

I wish to provide this Emergency Contact with access to my medical records, ask questions about and/or receive any test results. ☐ Yes ☐ No

COASTAL HEALTH | Injury

NEW PATIENT QUESTIONNAIRE

Account: _____ *(Staff only.)*

Date of Service: _____ Date of Injury: _____

Patient Name: _____D.O.B. _____

What is the main condition/body part for which you are seeking medical care?_____

What is the date of onset for the main condition stated above? _____

Is this condition today the result of an accident or traumatic injury? ☑ YES ❑ NO

What body parts are you here to have evaluated?

_____NECK:	❑ LT	❑ RT	_____BACK:	❑ UP.	❑ MID.	❑ LOW.
_____SHOULDER:	❑ LT	❑ RT	_____HIP:	❑ RT	❑ LT	
_____ELBOW:	❑ LT	❑ RT	_____KNEE:	❑ RT	❑ LT	
_____WRIST/HAND:	❑ LT	❑ RT	_____ANKLE/FOOT:	❑ RT	❑ LT	
_____CHEST:	❑ LT	❑ RT	_____ABDOMEN:	❑ RT	❑ LT	
_____HEAD/FACE:	❑ LT	❑ RT	_____OTHER:			

Have you received any physical therapy and/or chiropractic treatment? ☑ Yes ❑ No

If yes, list physician name: _____

What type of physical therapy and/or chiropractic care? _____

Have you had any prior injuries? ❑ Yes ❑ No

If yes, please identify/describe: _____

Have you had any diagnostic testing related to the condition that you are seeking orthopedic treatment?
MRI ❑ CT Scan ❑ CT/Myelogram ❑ X-ray(s) ❑ Nerve Test ❑ Discogram ❑

With regard to your present condition, have you had same/similar pain in the past? ❑ Yes ❑ No

If yes, have you had any prior treatment? ❑ Yes ❑ No

What type of treatment (ie.Medication, physical therapy, chiropractic, braces, heat, cold)? _____

Have you received treatment through a Pain Management Clinic? ❑ Yes ❑ No

If yes, what clinic? _____

What type of Pain Management treatment? _____

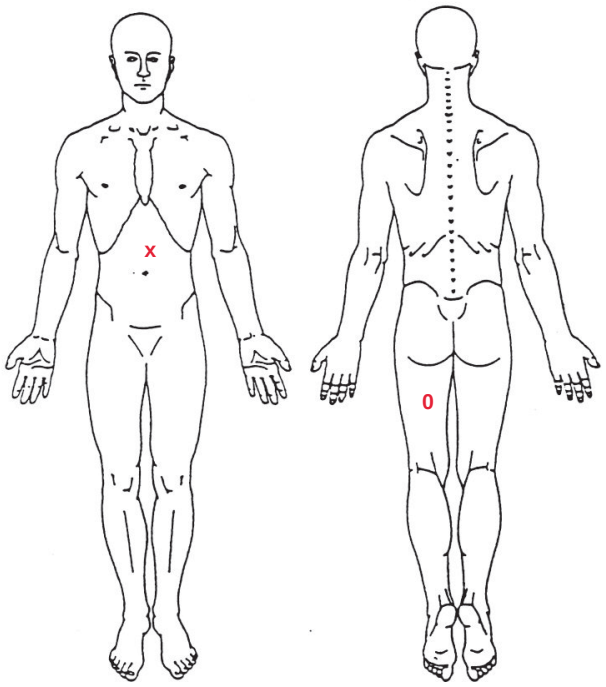
Date of last office visit? _____

PATIENT INITIALS: _____

Continued....

BODY DIAGRAM:

Instructions: Please indicate on the diagram below where your pain is located at the present time.
Please DO NOT indicate areas of pain that are not related to your present injury or accident condition presented today.
Place an "X" in the area(s) you have pain and a "0" in the area which you are experiencing numbness and/or tingling.
Thank you!



☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain **Worst Possible Pain**

If you have indicated arm pain, which arm bothers you more?	RIGHT ❑	LEFT ❑
If you have indicated leg pain, which leg bothers you more?	RIGHT ❑	LEFT ❑
If you have indicated neck pain, does the pain radiate?	YES ❑	NO ❑
Have you experienced and numbness in tingling?	YES ❑	NO ❑

If yes, in what body part(s) do you experience the numbness/tingling? _____

Have you experienced any changes in urination and/or bowel habits? YES ❑ NO ❑

If yes, please explain: _____

Do you have difficulty walking? YES ❑ NO ❑

If yes, how far can you walk before it hurts too much to go any further?

Less than a block ❑ One to three blocks ❑
More than four ❑ I have difficulty getting to the mailbox ❑

PATIENT INITIALS: _____

Continued....

HISTORY OF PRESCRIPTION MEDICATIONS:

What medications are you presently taking, including vitamins, supplements, herbal and any over the counter medications? Please list.

_____

_____

Are you allergic to any Medications?

Do you have any allergies to contrast dye, shellfish, or latex?

Past Medical History

Do you have any history of the following conditions?

☐ High Blood Pressure
☐ Osteoarthritis
☐ Thyroid Disease
☐ Diabetes
☐ Kidney Disorder
☐ Stroke
☐ Rheumatoid Arthritis
☐ High Cholesterol
☐ Asthma
☐ Coronary Artery Disease

Cancer (please indicate what type) _____

SURGICAL HISTORY:

Prior surgeries/hospitalizations? (please list any/all prior surgeries) _____

_____

_____

_____

PATIENT INITIALS: _____

Continued....

FAMILY HISTORY:

Please check any/all chronic illnesses that have affected immediate family members (parents, grandparents, siblings, aunts/uncles, children, etc).

____SUGAR DIABETES	____HIGH BLOOD PRESSURE	____ASTHMA/BRONCHITIS
____HEADACHES	____ANXIETY/DEPRESSION	____HISTORY OF CANCER/TUMORS
____SEIZURES	____SLEEP PROBLEMS	____RHEUMATOID
____ARTHIRITIS	____BOWEL PROBLEMS	____URINATION PROBLEMS
____HIGH CHOLESTEROL	____KIDNEY DISORDER	____OSTEOARTHRITIS
____THYROID DISEASE	____STROKE	____CORONARY ARTERY DISEASE

OTHER: _____

SOCIAL HISTORY:

Do you smoke cigarettes? YES ❑ NO ❑

If yes, how many packs per day? _____ How many years?____

If you were a prior smoker, how long ago did you quit smoking? _____

Do you drink alcohol? YES ❑ NO ❑

If yes, how often? _____

Do you exercise? YES ❑ NO ❑

If yes, how often? _____

Are you currently working? YES ❑ NO ❑

If yes, what is your occupation? _____

If you are not working, please choose one of the following:

RETIRED ❑ LEAVE OF ABSENCE ❑ STUDENT ❑ SEEKING EMPLOYMENT ❑

HOMEMAKER ❑ DISABLED / CURRENTLY ON DISABILITY ❑

OTHER: _____

Do you have children? YES ❑ NO ❑

If yes, how many? _____, & what are their ages? _____

Which hand is your dominant hand? RIGHT ❑ LEFT ❑

What types of hobbies/activities do you like to participate in, but have not been able to do so because of your current level of pain associated to this injury/accident? _____

PATIENT INITIALS: _____

Continued....

REVIEW OF SYMPTOMS:

General-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Head-
- ☐ Headache
- ☐ Head injury
- ☐ Neck Pain

Ears-
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes-
- ☐ Vision Loss/Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam:_____

Nose-
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat-
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

Neck-
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts-
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breastfeeding

Respiratory-
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular-
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Urinary-
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

Vascular-
- ☐ Calf pain with walking
- ☐ Leg cramping

Musculoskeletal-
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic-
- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine-
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Psychiatric-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

PATIENT INITIALS: _____

COASTAL HEALTH | Injury

INSURANCE - PHYSICIAN - ATTORNEY - PIP

Account: _____ *(Staff only.)* Date of Service: _____

Patient Name: _____D.O.B. _____

AUTO CARRIER NAME: _____

Adjuster Name: _____ Phone Number: _____

Claim Number: _____ Date of Accident: _____

TREATING PHYSICIAN NAME: _____

Phone Number: _____

Address: _____ City, State, Zip: _____

ATTORNEY NAME: _____

Firm Name: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Patient Authorization for Use and Disclosures of Protected Health Information to Third Parties

Section must be completed for all authorizations.

I hereby authorize the use and/or disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

List persons that you authorize our office to release your protected health information:

Name	**Relationship**
1. _____	My Physician
2. _____	My Attorney
3._____	
4._____	

The patient or the patient's representative must read the following statements:

I understand that I may revoke this authorization at any time by notifying Coastal Health - Injury in writing, and if I do, it will not have any effect on any actions they took before they received the revocation.

Signature of patient or representative: _____ Date: _____

Printed name of patient's representative: _____

Relationship to patient: _____

Form MUST be completed before signing. --- **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ---**

Continued....

AUTOMOBILE INSURANCE (PIP) INFORMATION:

Auto Insurance Carrier: _____ Claim #: _____

Policy Holder Name: _____ Policy #: _____

Policy Holder D.O.B.: _____ SSN: _____

Relationship to patient:
Self ❑ Spouse ❑ Child/Dependent ❑ Other ❑

Are you being seen as a result of an Injury or Accident? Yes ❑ No ❑

What Type of Injury or Accident:
Auto ❑ W/C ❑ Slip & Fall ❑ Other ❑

Date of Injury: _____

I HEREBY AUTHORIZE AND RELEASE any and all information to my insurance companies and/or attorneys and permit, and hereby permit a copy of this authorization to be used in place of the original for this purpose.

I HEREBY AUTHORIZE Coastal Health - Injury, my doctor and/or his employees to act as my agent assisting to obtain payment from my insurance company/companies, and I further authorize payment from my insurance company directly to Coastal Health - Injury for services rendered, or in the alternative, to the party who accepts the assignment.

I FURTHER UNDERSTAND that I am ultimately individually responsible for my balance, including co-payments, co-insurance and/or deductibles that must be met based on the policy limits outlined by my insurance company, who, by my instruction, shall be billed for any/all consented treatment rendered by Coastal Health - Injury. I further agree to individually assume the responsibility for any unpaid balance. I understand and agree to pay any/all associated costs and reasonable attorney's fees, or agency fees charged for collection of the unpaid balance for the authorized services rendered that are not paid for and/or found to not be covered, which may be placed with an attorney or collection agency for collection.

My signature below hereby attests that I have reviewed the information above, and I hereby certify that the information provided on this document is, to the best of my knowledge, complete and correct.

Signature: _____ Date: _____

COASTAL HEALTH | Injury

FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Coastal Health - Injury. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

AUTHORIZATION TO NEGOTIATE/SETTLE

I further authorize the Provider to negotiate, collect, and settle any claim with any insurance carrier or other third party payer with regard to these services, which authorization shall include but is not limited to authority to: 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, any Independent Medical Examination Reports, policies, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me, and 2) to endorse in my name on any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

FINANCIAL POLICY

I acknowledge, as the patient who received medically necessary, related and reasonable medical treatment from Coastal Health - Injury, that I remain personally liable for any deductibles and/or copayments owed pursuant to my insurance policy's language and Florida law. I fully understand that the medical services were provided to me in consideration for providing this assignment and these instructions to my insurance company. I understand that I am responsible for any amounts not paid by my insurer, including but not limited to any deductible, copayments or other amounts due and these are owed to Coastal Health - Injury by me regardless of any judgment or settlement in a personal injury or wrongful death action. I understand that Coastal Health - Injury will bill me for these amounts as soon as practicable after these amounts are determined by my insurer's response to Coastal Health - Injury's bills.
By executing the foregoing document, I am placing my insurer on notice that the claims for medical services provided to me by Coastal Health - Injury are related to my accident and should be paid directly to Coastal Health - Injury pursuant to any assignment of benefits or applicable Florida law. Any delay caused by my insurer's failure to make swift and automatic payments of my PIP benefits pursuant to my insurance company could adversely affect me.

FINANCIAL AGREEMENT

I hereby guarantee payment of all charges incurred for services rendered at Coastal Health - Injury. I understand the cost of my medical care is dependent upon the nature and complexity of my illness or injury, the determination of which can only be established by the physician or medical practitioner in charge of my care. I agree that the charges presented to me are reasonable. I understand that any verbal information given to me by any center staff regarding fees and services is for informational purposes only and is in no way a contract between Coastal Health - Injury and me. No verbal contracts will be made, or will be honored. I agree that no arrangement has been made between myself, the patient, and Coastal Health - Injury for medical services in exchange for a promise of payment for my medical expenses from any judgment or settlement of any personal injury or wrongful death action I have, or may have. I understand that payment is due upon receipt of any bill.

Payment of patient balances is due within 60 days of receiving our bill. If you cannot make payment at that time, please discuss entering into a payment plan with our Front Office Coordinator. We do not participate in any arrangements in which we render treatment in exchange for a promise of payment from a judgment or settlement in a personal injury or wrongful death action and no agreement to participate in a payment plan of your bills will be contingent on the judgment or settlement of any case you have or may have. All bills are due in full.

WORKER'S COMPENSATION

We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS

We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, urine drug screenings, etc.) will not be included in the charges for Coastal Health - Injury. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Coastal Health - Injury will send my lab specimens to a laboratory that accepts my insurance. All lab screenings will be sent to Coastal Laboratories who is affiliated with Physicians Group Services unless your insurance requires it to go to another lab (i.e. Quest or LabCorp).

...continued

NO SHOW POLICY (Please initial)

____ There will be a $50.00 charge if you fail to show for your scheduled office appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

____ There will be a $175.00 charge if you fail to show for your scheduled in-office procedure appointment. It is your responsibility to notify the office 72 hours in advance if you are unable to keep your procedure appointment.

____ There will be a $2,700.00 charge if you fail to show for your scheduled surgery facility appointment. It is your responsibility to notify the office 72 hours in advance if you are unable to keep your procedure appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

FORM COMPLETION FEE

Due to the large volume of forms that we are required to complete, our office reserves the right to charge up to $25.00 per page for the completion of forms. Dictated letters are dealt with on a case-by-case basis.

PRIVACY POLICY

I have received a copy of Coastal Health - Injury's privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to Coastal Health - Injury (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my individual responsibility.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF THE RIGHTS AND BENEFITS UNDER THE POLICY OF INSURANCE.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Physicians Group Services, P.A. d/b/a Coastal Health - Injury. In the event I receive payment directly from my insurance company for services rendered by Coastal Health - Injury, I agree to endorse any check received to Coastal Health - Injury.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____ Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____

COASTAL HEALTH | Injury

STANDARD DISCLOSURE AND ACKNOWLEDGEMENT

Personal Injury Protection - Initial Treatment or Service Provided

CLAIM # _____

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were actually rendered. This means that those services **have already been provided.**

   Office or other outpatient visit for the evaluation and management of a new patient, A comprehensive history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name (PRINT or TYPE)	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

*Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.*

COASTAL HEALTH | Injury

ASSIGNMENT OF BENEFITS

I hereby assign to **COASTAL HEALTH - INJURY**, all my rights, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, and personal injury protection, rendered by the assignee as described in the attached medical claim form.

I acknowledge that I am still responsible for paying the above referenced group if the relevant insurer, plan, or payor does not pay the physician in full at their billed amount, in accordance with **Florida Statue 627.736 (5).**

Policy Name: _____ Policy Number: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
☐ Guardian or conservator of patient
☐ Beneficiary or personal representative of deceased patient
☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Physician Signature: _____

COASTAL HEALTH | Injury

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(*) SECTION REQUIRED FOR COMPLIANCY

*Patient Name:	*Birth Date:	Social Security No:
*Provider (Who is releasing information):		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax Number:	

I hereby authorize my protected health information from the above provider to be released to:

*Recipient's Name (Who is receiving the information):		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax Number:	

*This authorization will expire upon the following: (Fill in the Date or Event, but not both.)

(If no expiration is specified, this authorization will expire 90 days from the date signed.)

*The following information may be disclosed (Choose one of the following):

_____ *** All Medical Records covering dates _____ through _____

_____ *** Entire Medical Record

_____ *** Specific Medical Records _____

_____ *** Other (Specify): _____

***I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____ (Initial) If not applicable, check here (☐)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see & obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6. I may retain a copy of this form after I sign it.

**Signature of Patient / Guardian / Legal Representative:	Date:
(If not signed by the Patient) Print Name:	Relationship to Patient:

Legal Paperwork is required if not signed by the patient.

COASTAL HEALTH | Injury

INFORMED CONSENT AND AGREEMENT FOR TREATMENT WITH OPIOID ANALGESIC MEDICATIONS

Patient Name _____ **Date** _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management specialist to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management specialist undertakes to treat me based on this Agreement.

In the event I am prescribed opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain, I agree to use properly. I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist could prescribe such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician/PA/NP-patient relationship.

In this case, my provider will stop prescribing these pain- control medicines and will taper off the medication over a period of several days, as necessary, to lessen withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my physician before making any changes.

   • I understand that increasing my dose without the close supervision of my pain management specialist could lead to drug overdose, causing severe sedation, respiratory depression and death.

   • I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, “goose flesh,” abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to several weeks.

2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual if I am receiving such medication from my Coastal pain management specialist. Prescriptions for controlled stimulants or anti-anxiety medicines need to be coordinated with your pain management specialist.

3. I understand the side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching.. urinary difficulty, jerkiness, change in personality, sleep changes, potential for increased pain, risks to unborn children, changes in appetite, coordination, sexual desire and performance. Most side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my pain management specialist of any side effects that continue or are severe (such as sedation or confusion). I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work. I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain.

4. (FOR FEMALE PATIENTS ONLY) I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold Coastal Health - Injury, its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby.

5. I understand that the opioid medication is strictly for my own use. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory.

6. I understand I must contact my pain management specialist before taking benzodiazepines (drugs like Valium,

Continued...

Xanax or Ativan), sedatives (drugs like Soma or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I cannot consume alcohol or use recreational/illegal drugs (including marijuana, cocaine, heroin, etc.) while on opioid analgesic medications. If consumed, the consequence will be termination from the program. I understand that opioid prescriptions will not be mailed. During the time that my dose is being adjusted, I will be expected to return to the Coastal Health - Injury no less frequently than one time a month. After I have been placed on a stable dose, I will return to the Coastal Health - Injury whenever instructed by my pain management specialist.

7. I am responsible for my opioid prescriptions. I understand that refill prescriptions:

- Can only be written for a one-month supply and will *be filled at the same pharmacy*. I will update my record of pharmacy should it change.

- Shall be made *during regular office hours 8 AM - 5 PM*, Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays or on weekends. Prescriptions will not be mailed.

- Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication.

- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

- I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. Lost or stolen medicines will likely not be replaced.

- Shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least one week ahead to schedule pick-up for my prescriptions.

8. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. I agree, if this is the case, that I may need to be admitted for detoxification to appropriate facility.

- Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.

- Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping." when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged from Coastal Health - Injury.

- Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

9. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the pain management specialist that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the pain management specialist.

10. I agree to submit to urine, saliva and/or blood screens at anytime as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my

Continued...

medication in at any time for the pain management specialist to inspect.

11. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of opioid medication.

- Controlled medication therapy may be discontinued if patients: (i) develop tolerance which cannot be managed; or (ii) have side effects, which cannot be controlled.

- Discharge from Coastal Health - Injury will occur if: (i) patients become addictive or abusive of other medications and substances (this includes alcohol), (ii) increase their medications without prior approval from my pain management specialist, (iii) obtain non-authorized controlled medi-cations from other practitioners; (iv) fill prescriptions at multiple pharmacies; (v) sell, give away or otherwise divert the medications from their intended use; alter prescriptions; or (vi) other serious concerns arise. Coastal Health - Injury always cooperates with authorities if illegal activities occur.

12. I also understand that if I have a problem or question with any of the terms of this Agreement, I must make an appointment to discuss this with the pain management specialist and receive clarification before a problem or crisis situation arises.

13. I authorize the release of any information and medical records by the pain management specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

14. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Coastal Health - Injury, its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

By signing below, I certify that I have read the above Information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature: _____ Date: _____

Physician: _____ Date: _____

COASTAL HEALTH | Injury

NOTICE OF EMERGENCY MEDICAL CONDITIONS

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on _____ (fill in date of accident).

2. The basis for the finding of an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

_____	_____	_____
Name (PRINT or TYPE)	Signature of medical provider	Date

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate.

2. I understand the medical provider has determined I sustained an **Emergency Medical Condition** as a result of the injuries I suffered in the care accident.

3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____	_____	_____
Name (PRINT or TYPE)	Signature of injured patient/guardian	Date