Hopkins Clinic for Physical Medicine

6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

PATIENT INFORMATION FORM

Welcome to Hopkins Clinic. Help us help you by completing this form. Please answer all the questions completely. All information provided is strictly confidential. **If you do not understand a question or are unsure of the information, please ask for assistance**.

Name: (First)________________________ (Middle) _______________ (Last)__________________________

Address ______________________________________ City_____________________ State___ Zip ________

Home phone (____)_____________ Email _____________________can we email you? Yes____ No____

Cell phone (____)_____________Can we text you with appointment reminders? Y / N Cell Carrier__________

Soc. Sec. # : ______ - _____ - ______ Birth date ____/______/____ Sex: M / F

Single / Married / Divorced / Separated Spouse Name ________________________

Your Occupation _____________Work phone #: (____)_____________can we contact you there? Y or N

In emergency, contact _______________________________________Phone # (_____)____________________

Insurance Co. _____________________________Name of Primary policy holder: ______________________
ID # _________________________________ Group # ____

Secondary Insurance Co. ____________________ Name of Primary policy holder: _____________________
ID # _________________________________ Group # ____

Automobile Ins. Co. ________________________ Name of Primary policy holder: ______________________
Policy # ________________________________ Claim # ______________________________________
Date of Accident __________________

I have read all the questions thoroughly and to the best of my knowledge and memory at this time, the information I have given is accurate and complete. If accepted as a patient, I hereby give the doctor permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures as they may deem necessary in the diagnosis and/or treatment of my (their) condition

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_________________________________ ________________
Patient Name (please print) Date

____
Patient, Parent, Guardian or Patient's legal representative signature

Hopkins Clinic for Physical Medicine

6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

Having been accepted as a patient at Hopkins Clinic, (hereafter also called THE OFFICE), I understand and agree to the following conditions of acceptance:

1. CONSENT TO TREATMENT: I give THE OFFICE permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures as they may deem necessary in the diagnosis and/or treatment of my (their) condition. My signature below verifies my full understanding of this consent and, upon my request, any possible risks regarding the treatment will be explained to me. I acknowledge THE OFFICE has made no guarantee or assurance as to any results I may obtain from services received.

2. NOTIFICATION OF CHANGES: I will notify THE OFFICE of changes in my health status, home and work telephone numbers, mailing address, insurance benefits, attorney representing me in a personal injury law suit, and any information I have given on the patient intake forms.

3. RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and obtain reimbursement, I authorize THE OFFICE to furnish, upon written request authorized by me, any information in my medical record including photographs or computer images to any and all persons or organization which are or may be liable for all or any portion of my medical charges at THE OFFICE. I authorize THE OFFICE to release any information pertinent to my case to any insurance company or their representative involved in this case.

4. FILING INSURANCE CLAIMS: As a courtesy and at my request for THE OFFICE to accept delayed payment for my care, THE OFFICE will submit insurance claim forms for payment of my medical benefits. I authorize THE OFFICE to submit claims for each service rendered and charge usual, reasonable and customary charge in this area for each service.

5. ATTORNEY LIEN: In the event I receive medical payment benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or other reimbursement from any settlement, judgment or verdict on my behalf, I hereby authorize and direct my attorney to FIRST PAY THE OFFICE directly the amount due for services rendered before any other disbursements are made from any funds received by the attorney's office on my behalf. This attorney lien is binding on any and all attorneys involved in my case prior to and subsequent to the date of this agreement with THE OFFICE. I may only revoke this lien by a certified letter received at THE OFFICE. I also give power of attorney to THE OFFICE to endorse/sign my name on any check received in my name for services rendered and owing THE OFFICE.

6. GUARANTEE OF PAYMENT: I understand and agree I am personally responsible for all services received at THE OFFICE, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgment or verdict on my behalf. I understand if my account at this office is past 60 days overdue, it may be subject to a 1.5% per month (18% per year) finance charge. If the defaulted amount is referred to a collection agency an/or for legal action I agree to pay for reasonable court costs and other costs of collection.

ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of HOPKINS CLINIC to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to HOPKINS CLINIC the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by HOPKINS CLINIC.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by HOPKINS CLINIC, is hereby directed to issue payment for those benefits directly to and payable to HOPKINS CLINIC.

I also authorize and assign to HOPKINS CLINIC the right to file suit and pursue all legal remedies to obtain payment for services provided to me by HOPKINS CLINIC. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by HOPKINS CLINIC and includes the assignment to pursue declaratory relief or any other legal remedies.

HOPKINS CLINIC accepts the aforesaid assignment and hereby notifies any insurer issuing payment that HOPKINS CLINIC objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to HOPKINS CLINIC a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to HOPKINS CLINIC a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by HOPKINS CLINIC have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by HOPKINS CLINIC, or made payment to HOPKINS CLINIC at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify HOPKINS CLINIC that benefits have been exhausted except for the amount held in escrow, to enable HOPKINS CLINIC to attempt to resolve the disputed claim in a manner acceptable to HOPKINS CLINIC.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my

complete medical records in possession of such insurer to HOPKINS CLINIC upon the request of HOPKINS CLINIC. This authorization includes the authorization to release to HOPKINS CLINIC a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to HOPKINS CLINIC of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

A photocopy of this agreement shall be considered as effective and valid as the original.

__________________________________ ________________________
Patient’s signature (or guardian’s signature) Date

__________________________________ ________________________
Witness to patient or guardian’s signature Date

__________________________________ ________________________
Authorized signatory for medical provider Date

Hopkins Clinic for Physical Medicine

6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. 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: ____ **ID Number:** _____________________________

Persons/organizations providing the information:

____

____

____

____

Person/organizations receiving the information:

Hopkins Clinic
6231 66TH Street North
Pinellas Park, FL 33781
Tel: 727 544 – 3330 Fax: 727 544 – 3221

Specific description of information (including date(s)):

___X-ray films ___X-ray Reports ___MRI Reports ___CT Reports ___Narrative Reports

___Nerve Conduction / EMG Reports ___Physical Therapy Progress Notes

___Emergency Room Records ___All Medical Records

Other ____

Dates: From ____________________ To ____________________

1. The provider must complete the following statement:

a. will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_________ No **XXX**___

2. The patient must read and initial the following statement:

a. I understand that I get a copy of this form after I sign it. Pt. initials:________

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

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YYYY) Initials: _________
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: ________

____ ____________________________

Signature of patient or patient's representative Date

(*Form MUST be completed before signing)*

Printed name of patient's representative: ____

Relationship to the patient: ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

THIS RECORDS RELEASE FORM IS HIPAA COMPLIANT

HIPPA form (Rev. 090106)

Hopkins Clinic for Physical Medicine

6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PAY.

Known by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint HOPKINS CLINIC, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said HOPKINS CLINIC, which checks, drafts or money orders are made payable for services which have been made by HOPKINS CLINIC, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows HOPKINS CLINIC, or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to the said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said HOPKINS CLINIC as attorney to the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of the same to HOPKINS CLINIC or any insurer providing coverage to me in connection with the processing of any claim for the benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, ____________________________________Hereby authorize____

(Name of Insured / Patient) (Name of Insurance Carrier)

To make medical benefits payments otherwise payable to me for services rendered by HOPKINS CLINIC, but not to exceed the charges of those services, payable to and mailed directly to:

HOPKINS CLINIC FOR PHYSICAL MEDICINE
6231 66th STREET NORTH
PINELLAS PARK, FL 33781

Furthermore, I hereby IRREVOCABLY ASSIGN to HOPKINS CLINIC the rights and benefits and any causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service provided by HOPKINS CLINIC and the charges therefore. Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by HOPKINS CLINIC are to be held in escrow and not to be disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this_____ day of _____________, 200__.

_______________________________________ _________________________________

PATIENT'S SIGNATURE PATIENT'S NAME (PLEASE PRINT)

Hopkins Clinic for Physical Medicine
6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

Date: ______________________

To My Attorney: ___________________________________

____

____

Re: Letter of Protection

Dear __________________________;

Please provide at your earliest convenience a **Letter of Protection** to Hopkins clinic for Physical medicine confirming that the fees / services will be protected at the time of settlement / adjudication of my case.

Thank you for your assistance in this matter.

Sincerely,

____
Signature

____
Printed Name

Hopkins Clinic for Physical Medicine
6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER: ______________________________

PIP POLICY NUMBER: ____________________________

NAME OF INSURED: ______________________________

DATE OF ACCIDENT: _____________________________

I, ______________________________ hereby authorize and direct
(Patient name)

____
(Insurance Company)

to send to **Hopkins Clinic for Physical Medicine at 6231 66th Street North, Pinellas Park, FL 33781** an accounting of payouts made under **all claims** submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date **as those payouts occur**.

_____________________________________ _______________________
Signature of Insured Date Signed

____
Representative of Hopkins Clinic