MOBILITY
SPINE AND SPORTS
LETS GET MOVING

LAST NAME FIRST NAME MIDDLE

D.O.B. EMAIL ADDRESS SOCIAL SECURITY #

COMPLETE ADDRESS

PHONE {HOME} {CELL} {WORK}

EMERGENCY CONTACT NAME AND TEL. #_____

MARITAL STATUS M___ S___ D___ W___ SEP___ RACE/ETHNICITY WHITE___ BLACK___ HISPANIC___ OTHER___

WAS IT AN ACCIDENT? YES___ NO___ AUTO___ WORK COMP___ SLIP FALL___ OTHER_____

ADDRESS OF RESPONSIBLE PERSON PHONE NUMBER

PRIMARY INSURANCE {ID#} {GROUP#}

SECONDARY INSURANCE {ID#} {GROUP#}

REASON FOR YOUR VISIT _____

WHAT TRIGGERED YOUR SYMPTOMS? SITTING___ BENDING___ LIFTING___ WALKING___ SPORTS___ ACCIDENT___

UNSURE___ OTHER_____

WHERE ON YOUR BODY DID YOUR PAIN START? _____

REFERING PHYSICIAN _____ FAMILY PHYSICIAN_____

WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

TREATMENT EVALUATION OF CURRENT PROBLEM: PHYSICAL THERAPY___ ICE THERAPY___ HEAT THERAPY___
COTISON INJECTION___ TRACTION___ BACK SUPPORT___ TENS UNIT___ CHIROPRACTIC CARE___
ACUPUNCTURE___ HOME/WATER EXCERCISES___ EPIDURAL INJECTIONS___ X-RAYS___ CT SCANS___ MRI___
EMG/NERVE STUDY___ BLOOD TESTS___ MEDICATIONS___

SIGNATURE DATE

Constitutional Symptoms		
Good general health lately	yes	no
Recent weight change	yes	no
Fever	yes	no
Fatigue	yes	no
Headaches	yes	no
	yes	no

Eyes	yes	no
Eye disease or injury	yes	no
Wear glasses or contact lenses	yes	no
Blurred or double vision	yes	no

Ears/Nose/Mouth/Throat		
Hearing loss or ringing	yes	no
Earaches or drainage	yes	no
Nose bleeds	yes	no
Mouth sores	yes	no
Bleeding gums	yes	no
bad breath or bad taste	yes	no
Sore throat or voice change	yes	no
Swollen glands on neck	yes	no

Cardiovascular		
Heart trouble	yes	no
Chest pain or angina pectoris	yes	no
Palpitation	yes	no
Shortness of breath when walking or lying flat	yes	no
Swelling of feet ankles or hands	yes	no

Respiratory		
Chronic or frequent cough	yes	no
Spitting up blood	yes	no
Shortness of breath	yes	no
Wheezing	yes	no

Gastrointestinal		
Loss of appetite	yes	no
Change in bowel movements	yes	no
Nausea or vomiting	yes	no
Frequent diarrhea	yes	no
Painful bowel movement	yes	no
Constipation	yes	no
Rectal bleeding or blood in stool	yes	no
Abdominal pain	yes	no

Genitourinary		
Frequent urination	yes	no
Painful urination	yes	no
Blood in urine	yes	no
Change in the force of strain when urinating	yes	no
Incontinence or dribbling	yes	no
Kidney stones	yes	no
Sexual difficulty	yes	no
Male-Testicular pain	yes	no
Female-Irregular periods	yes	no
Female-Vaginal discharge	yes	no
Female-# of pregnancies	yes	no
Female-# of miscarriages	yes	no
Female-Date of last pap smear	yes	no

Musculoskeletal		
Joint pain	yes	no
Joins stiffness or swelling	yes	no
Weakness of muscle/joint	yes	no
Back pain	yes	no
Cold extremities	yes	no
Difficulty walking	yes	no

Integumentary (Skin/Breast)		
Rash or itching	yes	no
Change in skin color	yes	no
Change in hair or nails	yes	no
Varicose veins	yes	no
Breast pain	yes	no no
Breast lump	yes	no
Breast Discharge	yes	

Neurological		
Frequent or recurring headaches	yes	no
Light headed or dizzy	yes	no
Convulsions or seizure	yes	no
Numbness or tingling	yes	no
Sensation	yes	no
Tremors	yes	no
Paralysis	yes	no
Head injury	yes	no

Psychiatric		
Memory loss or confusion	yes	no
Nervousness	yes	no
Depression	yes	no
Insomnia	yes	no

Endocrine		
Glandular or hormone problem	yes	no
Excessive thirst or urination	yes	no
Heat or cold intolerance	yes	no
Skin becoming dryer	yes	no
Change in hat or glove size	yes	no

Hematologic/Lymphatic		
Slow to heal after cut	yes	no
Bleeding or bruising tendency	yes	no
Anemia	yes	no
Phlebitis	yes	no
Past transfusion	yes	no
Enlarged glands	yes	no

Date of last:

Mammogram: _____

Pap Smear: _____

PSA: _____

Colonoscopy: _____

Other Tests:

_____

_____

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____

Signature of Patient, Parent or Guardian

Date

Release of Information

Release of Information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet a policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer", obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written consent.

FINANCIAL POLICY

Signing this form allows Mobility Spine and Sports to treat you, and bill any insurance's you may have, share information with other health care offices/facilities, and collect on your account.

Co-payments, Co-insurances, Deductibles, and Non-covered services are the responsibility of the patient/guarantor and expected at the time of service.

I authorize treatment by the providers of Mobility Spine and Sports. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Mobility Spine and Sports. If the correct insurance is not provided or the proper referral is not obtained, then patient acknowledges full responsibility for the bill.

I acknowledge that I received or read a copy of the Notice of Privacy Practices, which are posted in the waiting room.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable Attorney's Fee, Collection Agencies Fee, court costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

_____

Patient/Guardian Signature/Date Relationship to Patient

DR. DARIN BUSH
3101 N. Federal Highway, Suite 201, Fort Lauderdale, Fl. 33306

ASSIGNMENT OF BENEFITS

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

I, the undersigned patient/Insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance. a/k/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Patient's Name: _____

Patient's Signature _____

(If patient is a minor, signature of parent/guardian)

Date _____

MOBILITY SPINE AND SPORTS

Pain Management Form

The purpose of this agreement is to prevent misunderstandings about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled substances.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and my doctor undertakes to treat me based on this agreement. I will not attempt to obtain any controlled medication(s), including opiod pain medication(s), controlled stimulant's, or antianxiety medications from any other doctor. I understand that if I break this agreement, my doctor will stop prescribing pain controlling medications. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication helps to relieve the pain. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medication(s) with anyone. In this case, my doctor will taper off the medication(s) over a period of several days, as necessary, to avoid with-drawl symptoms. Also, a drug-dependence treatment program may be recommended. I will safeguard my medication(s) from loss or theft. I understand lost or stolen medication(s) will not be replaced. I agree that refills for pain medication(s) will only be made at time of an office visit during regular business hours. No refills will be available during weekends or after normal business hours. I agree to submit to blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications. I agree to use my medication(s) as directed and understand use greater than as directed may result in being without medication.

Pharmacy information _____

_____

_____

Tel:_____

I authorize the doctor and my pharmacy to cooperate fully with any, city, state or federal law enforcement agency, including this state's Board of Pharmacy in the investigation of my possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respects to these authorizations.

_____ **Patient Signature**

Date **Physician Signature** **Date**