690 NE 3rd Ave, Ste 104, Crystal River, FL 34428
Ph# 3523640045, Fax# 332 364 0045

6735 Conroy Rd, Ste 232, Orlando FL 34428
Ph # 407 545 4449, Fax# 352 364 0045

PATIENT INFORMATION

Date: _____

Patient Name: _____ M F
(Last) (First) (Middle) (Circle One)
Street Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Mailing Address: _____ Apt. # _____
(if different from above)
Date of Birth: _____ Referred By: _____
Social Security Number: ____-_____-____ __Marital Status: _____
Race_____**Ethinicity**_Hispanic, latino or Non Hispanic or Unknown
Email Address: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Preferred Laguage_____

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to patient: _____
Address: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____
(If patient is over 18, parent/guardian must have the patient sign a medical records release to obtain clinical information)

Insurance Information

Primary Insurance Name: _____ Phone Number: (___)_____
Insurance Address: _____
Subscriber Name: _____ Date of Birth : _____
Subscriber ID: _____ Group Number: _____

Access Rehab & Rejuvenation, LLC requires patients to call and cancel a scheduled appointment as soon as possible. We prefer to hear from you within 24 hrs prior to the appointment if you need to cancel or reschedule appointment. Several no-showed appointments will result in patients being terminated from Access Rehab & Rejuvenation, LLC.
I acknowledge prior receipt of Notice of privacy Practices and that no warranty or guarantee has been made to me as to result or cure. I certify that I understand this statement.

Signature_____ **Date**_____

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT

Phone: 352 364 0045
Fax: 352 364 0047
690 NE 3td Ave
Ste. 104
Crystal River
FL 34423

Request for Release of Medical Records

Date: _____
To: _____
_____
_____
_____

I Hereby Request That My Medical Records Be Released To:
Access Rehab & Rejuvenation, LLC.
690 NE 3rd Ave, Ste 104
Crystal River, FL 34428
Ph. 352 62 0045
Fax.352 364 0047

Patient Name:_____
Date of Birth: _____
Social Security Number:_____
Address:_____
_____
_____
Signature:_____ **Date:**_____

Confidentiality Note: The Information contained in this facsimile massage may be legally privilege and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any use ,dissemination, distribution or coping of the information strictly and may result in violations of federal or state law.

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize to use and/or disclose the ACCESS REHAB AND REJUVENATION LLC protected health information described below to .

2. Authorization for Release of Information covering the period of health care from all past, present, and future periods:

I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
OR

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until , at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Patient or Personal Representative **Date:**

_____

Print Name of Patient or Personal Representative Relationship to Patient

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To our patients:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning responsibility for payment for medical services provided to our patients, the following information is supplied:

The patient or their guarantor is responsible for payment for services provided by **Access Rehab & Rejuvenation, LLC** at the time of service. The only exception is if **Access Rehab & Rejuvenation, LLC** has contracted with your HMO/PPO/POS or Medicare to accept the insurance payment as payment in full after all deductibles have been met and all co-pays has been paid.

Charges for an office visit range from $100 to $500 +. Additional services such as laboratory maybe an additional charge and you will be billed separately.

HMO/PPO/POS or other Contracted Insurance Coverage:
If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card. Failure to provide this will result in your paying the full amount of the visit at the time of service. Payment of your deductible, co-payment and/or non-covered service is expected at the time of service.

MEDICARE:
Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their **allowable** charges after **you pay your annual deductible** for the calendar year. If you have supplemental insurance we require a copy of your insurance card.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

In the event that my insurance company denies payment for services rendered, I accept responsibility for the payment due depending on my insurance company's contract with

Access Rehab & Rejuvenation, LLC.
In the event that I am not covered by insurance, I understand that I am responsible for payment in full.

I hereby authorize The Access Rehab & Rejuvenation, LLC to release any information acquired in the course of my examination or treatment that may be necessary to process my claim. In consideration of services rendered, I hereby authorize payment, not to exceed reasonable and customary charges, directly to Access Rehab & Rejuvenation, LLC.

Patient Signature:_____ **Date:**_____
Responsible Party:_____ **Date:**_____

ACCESS REHAB & REJUVENATION LLC

690 NE 3rd Ave, Ste. 104, Crystal River, FL 34428,, Phone: 352 364 0045, Fax: 352 364 0047

Last Name_____ **First Name**_____ **Date of Birth**_____

Date_____ _ Ht _____ Wt_____ Temp _____ BP_____ HR_____ RR _____

Primary Care Doctor:_____ Handedness Right Left

Are You Pregnant—Yes NO Not applicable

Please describe the location of your pain-

Head, face & mouth

Neck region (Cervical)

Upper shoulder & upper limbs

Upper back region (Thoracic)

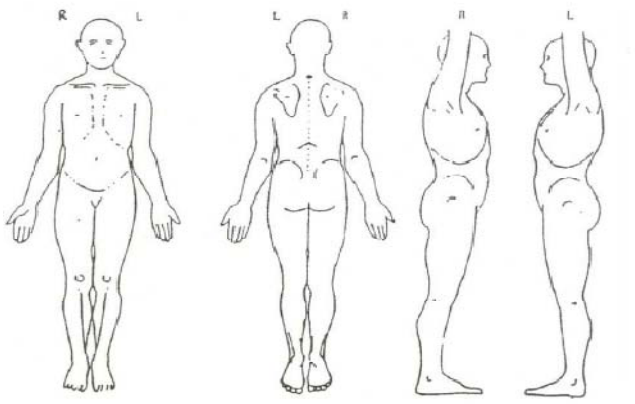
Abdominal region

Lower back, lumbar spine, sacrum & coccyx

Lower limbs

Pelvic region

Other_____



How long has this pain been present? *(date if known)*_____.

How did this pain begin? 1. Motor vehicle accident, 2.Accident at work, 3 Fall , 4. After surgery

Other: _____

Back pain goes to	Right	Left		Lower extremity		thigh	knee	Leg	ankle	
Neck pain goes to	right	left		Upper extremity		Shoulder	elbow	Forearm	hand	
Current pain level	1	2	3	4	5	6	7	8	9	10
Pain Level with Meds	1	2	3	4	5	6	7	8	9	10
Pain without meds	1	2	3	4	5	6	7	8	9	10
	No Pain									Worst Pain

Pain present- 1 Always/often present, always the same intensity, 2 Always/often present, intensity varies, 3 Recurring irregularly (e.g. like headache)4 Recurring regularly (e.g. premenstrual pain)

Pa**in is worst in**- morning afternoon evening Night all day and night

Patient pain affects. Mood work social function relations other _____

Pain aggravates with. Activity Work Prolonged sitting prolonged standing
Prolonged walking Bending Other_____

Pain Better with Hot packs Cold packs Stretching Changing positions sitting.

Tingling or numbness- Yes No Right Left Hand Forearm Arm Foot Leg
Thigh Other_____

History of Back Or Neck Surgery Yes No Type of Surgery_____.

Other Treatments Steroid injections Physical therapy Chiropractic manipulations
Other_____

Current Pain Medications_____

Side Effects with medication None nausea, vomiting, constipation, loss of appetite,

Signature of patient

ACCESS REHAB & REJUVENATION LLC
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HISTORY INFORMATION

MEDICAL HISTORY

_ Heart Disease	_ Cancer	_ Rheumatic Fever	_ Anemia
_ Stroke	_ Breast Lump	_ Tuberculosis	_ Bleeding Disorder
_ Diabetes	_ Prostate Problem	_ Hepatitis	_ Thyroid Problem
_ High Blood Pressure	_ Cataracts	_ Herpes	_ Kidney Disease
_ High Cholesterol	_ Glaucoma	_ Venereal Disease	_ Liver Disease
_ Asthma	_ Migraine Headaches	_ HIV/AIDS	_ Anxiety/depression
_ Emphysema	_ Epilepsy	_ Arthritis	_ Alcohol/drug Abuse

_ Other

DO YOU HAD ANY SURGIRIES

_____ _____ _____

_____ _____ _____

ALL CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

VITAMINS & SUPPLEMENTS:

_____ _____ _____

_____ _____ _____

ALLERGIES (If you are allergic to any of the following, please describe the reaction you had.)
Penicillin_____ Sulfa _____ Other_____
_____

LIFESTYLES AFFECTING HEALTH (Please answer these questions.)

Smoking-: Never_____ Age started_____ Age stopped_____
Cigarettes_____(packs/day) Cigars___ Pipe_____Snuff____ Chewing tobacco_____-
Alcohol: Never_____ 0-6 drinks/week _____7-14 drinks/week____ Over 14/week____
Special diet? Type:_____
Exercise: Type:_____ Frequency, distance or amount:_____

DOU ANY OF YOUR FAMILY MEMBERS HAS MAJOR MEDICAL PROBLEMS

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

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Review Of Systems

General
-Fevers
_ Chills
_ Sweats
_ Loss of appetite
_ Fatigue
_ Weakness
_ Malaise
_ Weight loss
_ Sleep Disorder

EYE
_ Blurring
_ Double vision
_ Irritation
_ Discharge
_ Vision loss
_ Eye pain
_ Eye pain in light

Ear/Nose/throat
-Earache
_ Ear discharge
_ Decreased hearing
_ Nasal congestion
_ Nosebleeds
_ Sore throat
_ Hoarseness
_ Difficulty swallowing

CARDIAC
_Chest Pain
_ Fainting
_ Shortness of breath walking
_ Shortness of breath laying flat
_ Shortness of breath at night
_ Leg swelling

RESPIRATORY
_Cough
_ Shortness of breath
_ Excessive sputum
_ Coughing up blood
_ Wheezing
_ Pleurisy
_ Pain with swallowing

GASTROINTESTINAL
_ Nausea
_ Vomiting
_ Diarrhea
_ Constipation
_ Change in bowel habits
_ Abdominal pain
_ Black Stool
_ Bloody Stool
_ Jaundice
_ Gas/Bloating
_ Indigestion/heartburn

NEUROLOGICAL
_ Numbness
_ Seizures
_ Tremors
_ Vertigo
_ Loss of vision
_ Frequent falls
_ Frequent headaches
_ Difficulty walking
_ Weakness
_ Fainting
_ Headache

PSYCHIATRIC
Depression
_ Anxiety
_ Memory loss
_ Suicidal thoughts
_ Hallucinations
_ Paranoia
_ Phobia
_ Confusion

ENDOCRINE
Cold intolerance
_ Heat intolerance
_ Increased Thirst
_ Eating more
_ Urinating more
_ Weight change

HEME/LYMPH
Abnormal bruising
_ Bleeding
_ Enlarged lymph nodes

ALLERGIC/IMMUNO
Hives
_ Allergic rash
_ Sneezing
_ Hay fever
_ Recurrent infections
_ HIV exposure
Rash

SKIN
_ Itching
_ Dryness
_ Suspicious lesions

FEMALE GENETOURINARY
Vaginal discharge
_ Incontinence
_ Pain with Urination
_ Blood in urine
_ Get up at night to urinate
_ Urinary frequency
_ Missed period
_ Heavy Period
_ Abnormal vaginal bleeding
_ Pelvic pain
_ Genital sores

MALE GENITOURINARY
Pain with Urination
_ Blood in urine
_ Discharge
_ Urinary frequency
_ Urinary hesitancy
_ Get up at night to urinate
_ Incontinence
_ Genital sores
_ Decreased Libido
_ Erectile dysfunction

MUSCULOSKELETAL
_Back pain
_ Joint pain
_ Joint swelling
_ Muscle cramps
_ Muscle weakness
_ Stiffness
_ Arthritis
_ Sciatica
_ Restless legs
_ Leg pain at night
_ Leg pain with exercise
Paralysis

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Chronic Opioid Analgesic Therapy Agreement

Patient Name: _____ Date:_____

Please read and attest to the following statements and circle T for True or F for False:

Risks Inherent in Chronic Opioid Analegesic Therapy:

Opioids, such as Morphine. Percocet, and Codeine, are the strongest known pain relievers. Studies suggest that they can be very helpful for some patients with chronic pain. Some patients report being able to do more when they take opioids, but others do not. This type of treatment does have risks.

The most common are listed below:

- Constipation.
- Decreased appetite.
- Confusion or other changes in mental state or thinking ability.
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
- Increased sleepiness or drowsiness.
- Breathing too slowly - an overdose can lead to respiratory arrest or death.
- Physical dependence - stopping use of the drug may lead to a withdrawal syndrome characterized by one or more of the following: runny nose, diarrhea, abdominal cramping, "goose" flesh, anxiety.
- Psychological dependence - stopping use of the drug may lead to craving and desire for the drug.
- Addiction - A small percentage of the patients may develop addiction problems based on genetic or other factors. People with past history of alcohol or drug abuse problems are more susceptible to addiction.
- Tolerance - Larger doses are needed to achieve the same effect.
- Children born to mothers using controlled substances are usually dependent on the drug at birth.
- Other, Less common risks and side effects are possible.

T F 1. I have not responded to other reasonable forms of treatment or they have produced too many side effects. I understand it is my responsibility to inform the doctor of any and all side effects I have from medications prescribed to me.

T F 2. I do not have problems with substance abuse or dependence.

T F 3. I have never been involved with the sale, illegal possession, diversion or transport of controlled substances (opioids, sleeping pills, nerve pills, or pain killers) or deception to obtain these substances.

T F 4. I agree that the opioids will be prescribed only by an Access Rehab & Rejuvenation physician and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other physician without first discussing it with any Access Rehab & Rejuvenation treating physician.

T F 5. Under no circumstances will I allow other individuals to take my medications.

T F 6. I agree to allow my physician to communicate with my referring physician and any other related health care professional (nurses, pharmacist, emergency services, ect.) regarding my use of controlled substances.

T F 7. I will follow the advice of my physician in regard to stopping controlled substances, should he/she feel it advisable.

T F 8. I agree to submit to urine and/or blood tests in order to properly assess the effect of the opioids concerning my health and compliance

T F 9. If a female of childbearing age, I certify that I am not pregnant and that I will use appropriate measures to prevent pregnancy during the course of treatment with opioids.

T F 10. As a general rule, I understand no allowance will be made for loss of prescription drugs.

T F 11. I will notify my doctor if additional opioids are prescribed for treatment of other unrelated problems (emergency room, dentist, other physicians) within 5 working days.

T F 12. If my doctor recommended, I will see a specialist for the determining whether I am developing an addiction.

T F 13. I understand that my doctor will not be available to prescribe medications during evenings and weekends. My doctors will not provide me with refills by phone especially at night or on weekends. It is my responsibility to call my doctor at least 3 business days in advance of running out of medications.

T F 14. I allow my doctor to receive information from any health care provider or pharmacist in this or any state about use or possible misuse or abuse of alcohol or other illicit drugs. I will also allow my doctor to disclose my health care information to the extent not permitted under law, so that my doctor can contact any health care provider, pharmacy, legal authority or regulatory agency to obtain or provide information about my care and/or actions during the course of my treatment and my prescriptions and use, misuse and/or abuse of the Opioids. The purpose of such use and disclosure is to facilitate the safe and legal prescribing to and use by me of the Opioids. The authorization provided in the Section 15 shall remain in effect for twelve months following the termination of my treatment. I have the right to revoke this authorization at any time by providing written notice to the doctor. There is potential that my protected health information disclosed by my doctor in

accordance with this authorization may be subject to further disclosure by the recipient thereof and no longer protected under HIPAA.

T F 15. I understand this mode of treatment may be stopped if any of the following occur:

- If my physician feels that opioids are not effective for my pain or that my functional activity is not improved.
- I give, sell, or misuse the medications.
- I develop rapid tolerance or loss of effect from this treatment.
- I develop side effects that are significant in the view of my doctor.
- I fail to comply with other parts of recommended treatment (i.e. physical therapy, behavioral management plan..ect.)
- I obtain opioids from sources other than my physician.
- I consistently fail to keep my scheduled appointments.

T F 16. I understand that my doctor will gradually take me off opioids according to medical standards or refer me for drug addiction treatment, including detoxification, If I do not follow the above plan or if my doctor believes that the opioids are harming me or not helping me. I have read this document, understand it, and have had all questions answered satisfactorily. I agree to the use of opioids to help control my pain. I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

Patient Signature:_____ Date:_____

Physician Signature: _____