

**ABACOA PHYSICAL MEDICINE & ORTHOPAEDICS**  
[www.abacoaphysicalmedicine.com](http://www.abacoaphysicalmedicine.com)

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of January 1, 2002, and will remain in effect until we replace it.

**CHANGES TO NOTICE:**

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:**

**A. TREATMENT, PAYMENT, and HEALTHCARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

**B. AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this notice.

**C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**D. MARKETING:** We will not use your health information for marketing communications without your written authorization.

**E. USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

**F. PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**G. LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

**H. APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

#### **PATIENT RIGHTS:**

**A. ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you the actual cost of copying, including reasonable staff time for labor, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

**B. ACCOUNTING OF CERTAIN DISCLOSURES.** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**D. AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

**E. ELECTRONIC NOTICES:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Lisa Weber, Administrator

Telephone: 561-622-6111

Fax: 561-622-1176

E-mail: [abacoaphysicalmedicine.com](mailto:abacoaphysicalmedicine.com)

Address: 600 University Blvd Ste 105, Jupiter, FL 33458

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may involve in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

Upon request, I can receive and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact **Abacoa Physical Medicine & Orthopaedics** at any time at 600 University Blvd Ste 105, Jupiter, Florida 33458 to obtain a current copy of the Notice of Privacy Practices. If you request copies of your clinical records, we will charge you \$1.00 for each page up to 25 pages and \$.25 for each page after 25 and any postage.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

**Patient Name** \_\_\_\_\_  
**Relationship to Patient** \_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

**Date** \_\_\_\_\_ **Initials** \_\_\_\_\_  
**Reason** \_\_\_\_\_

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

## Medical Records Release Authorization

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Doctor/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**I hereby authorize the release of my Medical Records to be sent to:**

Abacoa Physical Medicine & Orthopaedics

\_\_\_\_\_ 600 University Blvd Ste 105, Jupiter, Florida 33458 (561)-622-6111

\_\_\_\_\_ 160 NW Central Park Plaza Ste 101, Pt St Lucie, Florida 33458 (772)873-5226

\_\_\_\_\_ 3003 S Congress Ave Ste 2F, Palm Springs, Florida 33461 (561) 963-6227

\_\_\_\_\_ 5405 Okeechobee Blvd., Suite 304, West Palm Beach, FL 33417 (561) 255-3131

Thank you in advance for your prompt consideration.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
If patient is a minor Signature of Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness to above Signature

\_\_\_\_\_  
Please print Name

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**PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE**  
**(Please Read Carefully)**

At the present time, \_\_\_\_\_ is my insurance carrier.

I will inform Abacoa Physical Medicine & Orthopaedics of any changes with the above insurance carrier **immediately**.

As a participating Provider, Abacoa Physical Medicine & Orthopaedics has agreed to file a claim for services rendered.

I will be responsible to pay Abacoa Physical Medicine & Orthopaedics for the following:

- (1) Any co-payment as set by my insurance carrier
- (2) Any unsatisfied deductible
- (3) Any amount my insurance carrier deems my responsibility
- (4) Any amount considered non-covered by my insurance carrier
- (5) Termination of coverage

I certify that I am not enrolled in any Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that is **not contracted** with Abacoa Physical Medicine & Orthopaedics. I assume full responsibility for all physician charges should the above criteria not be met.

I further agree that I will be responsible for all collection costs, including legal fees and court costs should this matter be referred to an attorney or collection agency.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY ABACOA PHYSICAL MEDICINE & ORTHOPAEDICS.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# ABACOA PHYSICAL MEDICINE & ORTHOPAEDICS

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## 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 same to Abacoa Physical Medicine & Orthopaedics or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original page.

**Release of Information:** I hereby authorize this medical provider to: furnish my insurance company or companies with any and all information that may be contained in my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's express written permission.

## ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT

I consent to the plan of care and treatment by the physician, nurse practitioner, therapist and/or his/her assistants.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to release any  
(Name of insured) (Name of Insurance Carrier)  
benefit information to Abacoa Physical Medicine & Orthopaedics as they may require for treatment.

I assign my medical benefits otherwise payable to me for Abacoa Physical Medicine & Orthopaedics services, but not to exceed the charges of those services. I hereby, IRREVOCABLY ASSIGN to Abacoa Physical Medicine & Orthopaedics any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Abacoa Physical Medicine & Orthopaedics  
IN WITNESS WHEREOF the undersigned have here unto set their hands, this, \_\_\_\_ day of \_\_\_\_\_, 2010.

I authorize Checks to be made Payable to and mailed directly to: Abacoa Physical Medicine & Orthopaedics  
600 University Blvd Suite 105  
Jupiter, FL 33458

## CANCEL/NO-SHOW POLICY

Our offices consider Cancellation of Your Appointment or Not Showing for you're your Appointment a serious issue, because it can make the difference between whether you will or will not attain your treatment goals.

- Requires 24 hours advance notice
- Requires rescheduling an alternative appointment in order for you to receive the prescribed frequency of treatments for the week

There may be a \$25.00 fee for no-showing for an appointment without proper notice or without rescheduling. This charge is not covered by insurance and will be billed directly to you. If there is an extenuating circumstance, please let our office know. If this is a Worker's Comp claim, the charge will be waived and your employer will be notified.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE AND THAT I AUTHORIZE AND AGREE TO THEM.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PRINT NAME OF PATIENT / DATE

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW AND HAVE BEEN OFFERED A COPY OF ABACOA PHYSICAL MEDICINE'S "NOTICE OF PRIVACY PRACTICES"

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
PRINT NAME OF PATIENT / DATE

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**Health Insurance / Worker's Compensation Patient Health Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Marital Status: M S D W  
Spouse's Name: \_\_\_\_\_ Your Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_

Have you been to a Chiropractic Physician before? Yes No

Physician Name: \_\_\_\_\_

Have you been to a Pain Management/Physiatrist before? Yes No

Physician Name: \_\_\_\_\_

Have you been to an Orthopaedic Surgeon before? Yes No

Physician Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

May we let your PCP know you are treating with us? Yes No

Who may we thank for referring you to our office: \_\_\_\_\_

**All Patients must complete this section**

Chief Complaint:

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

Is the Pain: Constant Intermittent Sharp

When did the pain begin: \_\_\_\_\_

Is there anything which makes the pain worse? \_\_\_\_\_

Is there anything which makes the pain better? \_\_\_\_\_

What is the most comfortable position for you? Standing Sitting Laying Down Nothing is comfortable

Do you have any numbness or tingling in your: Arms Hands Fingers Legs Feet Toes

Do you have cramps in your arms or legs? Yes No

Do you have any dizziness or nausea? Yes No

Have you seen another physician for this condition? Yes No

If yes, Physician Name: \_\_\_\_\_

Is it possible you are pregnant? Yes No

Are you taking Nutritional supplements/Medication? Yes No

If yes, what medication/vitamin supplements? \_\_\_\_\_

**Health Insurance Information**

Primary Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a co-pay? Yes No    Do you have a deductible? Yes No

Secondary Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a co-pay? Yes No    Do you have a deductible? Yes No

Rev 1/1/10

**Workman's Compensation Insurance Information**

Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Adjuster's Phone # \_\_\_\_\_

Do you have a deductible? Yes No

Is this insurance in your name: Yes No

If no, please fill out the next section:

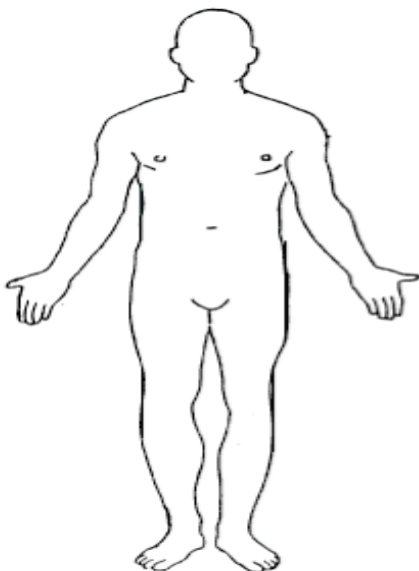
Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

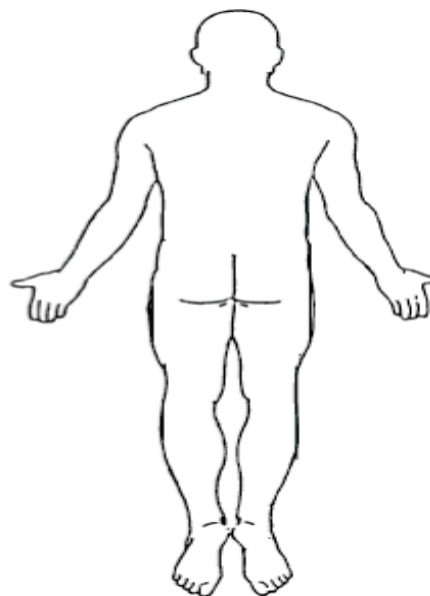
Insured Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Health History**

*Please draw where your pain is located on the diagram below*



- Numbness  
|| || ||
- Pins and Needles  
0 0 0 0
- Burning  
x x x x x
- Stabbing  
|||||
- Ache  
A A A A



**Please select all choices that apply to the Patient**

Abdominal Pain • Bulimia • Fainting • Irritable Colon • PMS • Sickle Cell Anemia • Allergies • Cancer  
Kidney Disease • Polio • Sinus Trouble • Angina • Headaches • Kidney Stones • Spinal Disc Disorder  
Anorexia • Convulsions • Heart Disease • Liver Disease • Prostate Disease • Stroke • Arthritis • High BP  
Lung Disease • Asthma • Dizziness • HIV/AIDS • MS • Scoliosis • Ulcer • Blood Disorder • Osteoporosis  
Breast Disorder • Sex Transmitted Diseases

List any other Medical Condition: \_\_\_\_\_

List any medical conditions that run in your family: \_\_\_\_\_

Do you live with someone other than yourself: \_\_\_\_\_

**Patient Exercises:** Rarely Moderately Regularly Never

**Patient Smokes:** 0-1 Pack per day 2 Packs per day Never

**Patient uses alcohol:** Rarely Moderately Regularly Never

**Allergies:** Dust Penicillin Pollen Sulfa Drugs Dander Dairy Products Latex  
Perfumes 2ndary Smoke Eggs Contrast Dye Soaps Meds \_\_\_\_\_

**Past Surgical/Hospitalization History**

**Type of Surgery/Cause of Hospitalization:**

\_\_\_\_\_ Date: \_\_\_\_\_

Where: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Complications: \_\_\_\_\_

**Type of Surgery/Cause of Hospitalization:**

\_\_\_\_\_ Date: \_\_\_\_\_

Where: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Complications: \_\_\_\_\_

**List all medications you are taking**

**Name/Dose:** \_\_\_\_\_

**Name/Dose:** \_\_\_\_\_

**Name/Dose:** \_\_\_\_\_

**Name/Dose:** \_\_\_\_\_

**Name/Dose:** \_\_\_\_\_

**Name/Dose:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Review of Systems (circle all that apply)**

**Cardiovascular:** chest pain • palpitations • artificial heart valve • hypertension • murmurs • fainting  
heart attack

**Respiratory:** shortness of breath • cough • tuberculosis (or exposure to TB) • wheezing • tightness  
snoring • asthma • sleep apnea

**Musculoskeletal:** muscle pain • joint pain • joint swelling • instability • stiffness

**Neurological:** headaches • dizziness • weakness • unsteady gait • numbness • seizures • tingling  
tremors • stroke

**Eyes:** glasses • double vision • tearing • blindness • blurred vision • glaucoma

**ENT:** hearing loss • ringing in ears • nose bleeds • trouble swallowing • earaches

**Dermatologic:** rash • itching • changes in hair • change in nails • skin changes • poor healing • redness

**GI:** nausea • vomiting • constipation • liver disease • black tarry stools • ulcers • heartburn  
diarrhea • hepatitis

**GU:** urgency • frequency • blood in urine • stones • retention • incontinence • difficult or painful urination

**Endocrine:** intolerance to heat/cold • diabetes • thyroid problems

**General:** weight loss • weight gain • fevers • chills • poor sleep • night sweats

**Psychiatric:** anxiety • depression • suicidal thoughts • substance abuse • nervousness • hallucinations

**Hematologic:** anemia • easy bleeding • previous transfusion reaction • bruising • blood clot  
excessive thirst or urination

**Lymphatic:** lymph node enlargement • lymph node tenderness • lymphadema

**Immunological:** immunocompromised • HIV/AIDS • latex allergy

**Height:** \_\_\_\_\_ ft \_\_\_\_\_ inches

**Weight:** \_\_\_\_\_ lbs

**I understand and agree that insurance policies are an arrangement between my insurance carrier and myself. This office will prepare and file all claims on my behalf to my insurance company.**

**I authorize payment to be paid directly to this office, which will be credited to my account upon receipt for any services furnished me by the physician. I understand that my signature also authorizes release of medical information necessary to pay the claim. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that all services rendered to me are charged directly to me and I am personally responsible for payment if my insurance company refuses to pay the claims in a timely manner. (45 days from initial filing shall be considered a timely manner)**

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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Dear Patient:

We would like to inform you that it is possible during your treatment by a doctor, chiropractor or other health care provider that you may be sent for imaging studies which may or may not include magnetic resonance imaging (MRI). In fact, it is possible that your health care provider may send you to Advanced Diagnostic Resources a radiology center in which Joshua Smith, D.C., whose office is located at 600 University Boulevard, has a financial interest and same is being disclosed as provided under Florida Statutes Section 456.052.

Obviously, you are free to use any provider of these services.

There are numerous alternate providers available such as:

Midtown Imaging which is located at 601 University Blvd Ste B-101 in Jupiter

Jupiter Open Imaging which is located at 875 Military Trail Ste 101 in Jupiter.

We thank you for your attention and consideration in signing below to acknowledge that you were informed of the above matter.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_