



PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Pedro T. Oliveros, MD, PT
Medical Director

Name: _____
Last First M Nickname

Address: _____
Street Apt City St Zip

Phone: _____
Best # to reach you at home/cell/work home/cell/work

Sex: M F Date of Birth ____/____/____ Age ____ Marital Status: Single/Married/Other

Social Security #: ____ - ____ - ____ Email address: _____

Emergency Contact: _____
Name Phone Relationship

Primary Care Physician: _____ Phone: _____

Address: _____
Street City St Zip

Health Insurance information: Private/Self pay, no insurance

Primary Health Insurance Company: _____

Policyholder's name: _____ Policyholder's DOB: ____/____/____

Your member/subscriber ID # _____ relationship to policyholder: _____

Secondary Health Insurance Company: _____

Policyholder's name: _____ Policyholder's DOB: ____/____/____

Your member ID # _____ relationship to policyholder: _____

Our front desk staff will need a copy of your driver's license and insurance card(s)

Auto Accident Patients:

Auto Insurance Carrier: _____

Date of Accident: ____/____/____ State accident occurred in: _____

Policyholder's name: _____ Relationship to policyholder: _____

Claim # _____ Were you the: Driver or Passenger

Do you have an attorney for this accident? Yes No

If yes, Attorney/Firm name: _____ Phone: _____

I represent and affirm that the above information is true and correct, and it is my understanding that Physical Medicine & Rehab Center of Orlando is relying on the above information that I provided. I have read the Consent for Treatment, Acknowledgement of Liability and Assignment of Benefits forms on the following pages and as the patient or patients authorized representative of general agent for the purpose of signing his form, I hereby accept its terms.

Patient or patients agent signature

Date

SERVICES PROVIDED

Onsite Massage/Physical Therapy (MM20830)
Neuro and Post-Surgical Rehabilitation
Wellness & Exercise Fitness Programs

Sports / Auto Accidents Injuries
DRS Lumbar Spinal Decompression
Dizziness & Fall/Balance Testing & Rehab

EMG/Nerve Conduction Studies
IME's/ Impairment Ratings
Therapeutic Botox Injections



PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Pedro T. Oliveros, MD, PT
Medical Director

Name: _____

Date: _____

The following questions are given to **all** patients at our facility. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (ex: marihuana, cocaine, etc) in the past 5 yrs?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

(References: Butler SF, Budman SH, Fernandez K, Jamison RN (2004) Validation of a Screener and Opioid Assessment Measure for Patients with Chronic Pain. Pain 112:65-75)

Dear Patient:

Our office is primarily a rehabilitation center focusing on active programs to control or minimize your pain with the goal of maximizing your function. Though there is no 100% guarantee that your pain will completely resolve, your compliance to the multidisciplinary treatment offered (physical therapy, psychological interventions, consultations, medications) is necessary. Strong pain medications (opioids/narcotics) are only prescribed to allow your participation in a progressively active physical rehabilitation program. The goal is to eventually minimize or taper off the use of medications as you recover. Too much reliance on pain medication and ignoring other treatment(s) (i.e. not showing up for your rehab visits consistently) will not be allowed. Similarly, any unethical or aberrant behavior by the patient will be grounds to discontinue the care of the patient (e.g., diversion, selling opioids to others, taking opioids for emotional reasons, "doctor shopping", taking illicit substances, sharing medications, not taking opioids as prescribed, etc). **If you are not compliant with your treatment you will be discharged from our clinic.** It is generally accepted that multidisciplinary treatment of chronic pain lead to best outcomes. If you need more information, the Medical Assistants can provide you with articles on Chronic Pain Management.

CONSENT FOR TREATMENT The undersigned hereby consents to the provision of examination, fitness evaluation, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patients health care provider of Pedro T. Oliveros Jr., MD, P.A their physician, nurse practitioners, physical therapist, certified athletic trainers or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

I have read, understood and agreed to the above.

Patient's Signature

Revised 03/10

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by Physical Medicine & Rehab Center of Orlando This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority:

CONSENT FOR TREATMENT The undersigned hereby consents to the provision of examination, fitness evaluation, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patients health care provider of Physical Medicine & Rehab Center of Orlando their physician, nurse practitioners, physical therapist, certified athletic trainers or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all test of any type or character to such person (s) as the Physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and /or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my polices including a copy of such policy and any information supporting documentation concerning or touching upon handling, calculation, processing, or payments of any claim.

DEMAND FOR PAYMENT To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility name above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility name above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefit, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY If patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by physician/ facility name above.

STATUTE OF LIMITATIONS Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by physician/ facility name above.

TERMS OF ATTORNEYS FEES Net 30 days from the date of invoice unless otherwise indicated. A finance charge of 1.5 % per month (Annual Percentage Rate 18%) of the unpaid balance will be added monthly, both pre-judgment and post-judgment. Should collection become necessary, the patient(s) agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/ facility named above.

LIMITED POWER OF ATTORNEY I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our addresses upon request in writing to the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable.

A PHOTOCOPY OF THE INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of Patient and/ or Responsible Party: _____

Address: _____ **City** _____ **St** _____ **Zip** _____

Date: _____

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Privacy Policy Notification

This notice describes the privacy policies of Physical Medicine & Rehab Center of Orlando. First and foremost, we strive to maintain confidentiality as far as medical treatment information. There are times, however, when identifiable health information must be disclosed to specific entities such as your insurance carrier. Herein we describe how this confidential health information is used and disclosed and how you can gain access to this confidential information.

Background Information:

Medical offices are required by applicable federal and state laws to maintain confidentiality of medical information generated for patients during their course of treatment. Through recent legislation, medical offices are now required to notify all patients about privacy practices, our legal duties concerning these practices, and your rights concerning your health information. These privacy policies take effect as of April 14, 2003, and will remain in effect until amended by this office.

We reserve the right to change the privacy practices of this office and the terms of this notice at any time, provided that the applicable law permits such changes. We reserve the right to make changes in our privacy practices effective for all health information that we collect and maintain, including prior medical information as well as information gathered before policy changes were determined to be necessary. As changes in our privacy practices are made, we will notify our patients of these changes and make amended privacy policy statements available upon request.

Our patients are welcome to request copies of our privacy policies at any time. Keep this information on file along with other documents from this office and check with our office staff for any amended versions or changes.

Uses and Disclosures of Health Information

This office uses and discloses health information about you and your family members for purposes of treatment, payment, and medical practice operations.

Your Authorization: In addition to our use of your health information for treatment, payment, or medical practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such authorization, you have the right to revoke it in writing at any time. Your revocation will not revoke any use or disclosures permitted by your authorization while it was in effect.

We may disclose your health information to a family member, friend, or other person the extent necessary to assist us with your medical care or with payment for your medical care, but only if you agree that we may do so.

We may disclose your health information when we are required to do so by law through a subpoena.

We may disclose medical information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect, domestic violence, or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

We may disclose medical information to military authorities under certain circumstances. We may also disclose medical information to correctional institutions or law enforcement officials having lawful custody of protected information of inmates or patients under certain circumstances.

We may disclose basic medical information insofar as the fact that you have a medical appointment scheduled in the form of appointment reminders such as voicemail messages, postcards, letters, or e-mails.

We will not make any disclosures of your health information to a greater degree than we consider minimally necessary for the purpose of each disclosure.

Patient Rights

- ❖ You have the right to read over or obtain copies of your medical information.
- ❖ You have the right to receive a list of instances in which the practice has disclosed medical information for purposes other than treatment, payment, or medical practice operations. IF requested more than once in a 6-month period, you may be charged a reasonable cost-based fee for responding to these additional requests.
- ❖ You have the right to request that we communicate with you regarding your medical information or treatment by alternative means. (Fax, e-mail etc.) This request must be in writing, and the method and/or location must be indicated as well.
- ❖ You have the right to request that we amend you medical information that has been provided to you. Your request must be in writing, and it must give a detailed explanation of why the information should be amended. We reserve the right to deny your request under certain circumstances.

Your right to privacy is very important to us. If you would like additional information about our privacy policies, or have questions or concerns, please feel free to contact our privacy officer.

PRINT NAME

SIGNATURE

DATE

BELOW PLEASE ENTER NAMES OF INDIVIDUALS YOU WOULD LIKE TO DISCLOSE ANY MEDICAL INFORMATION IN PERSON (THIS INCLUDES TELEPHONE, FAX OR EMAIL)

Name / Relation

Name / Relation

Name/ Relation

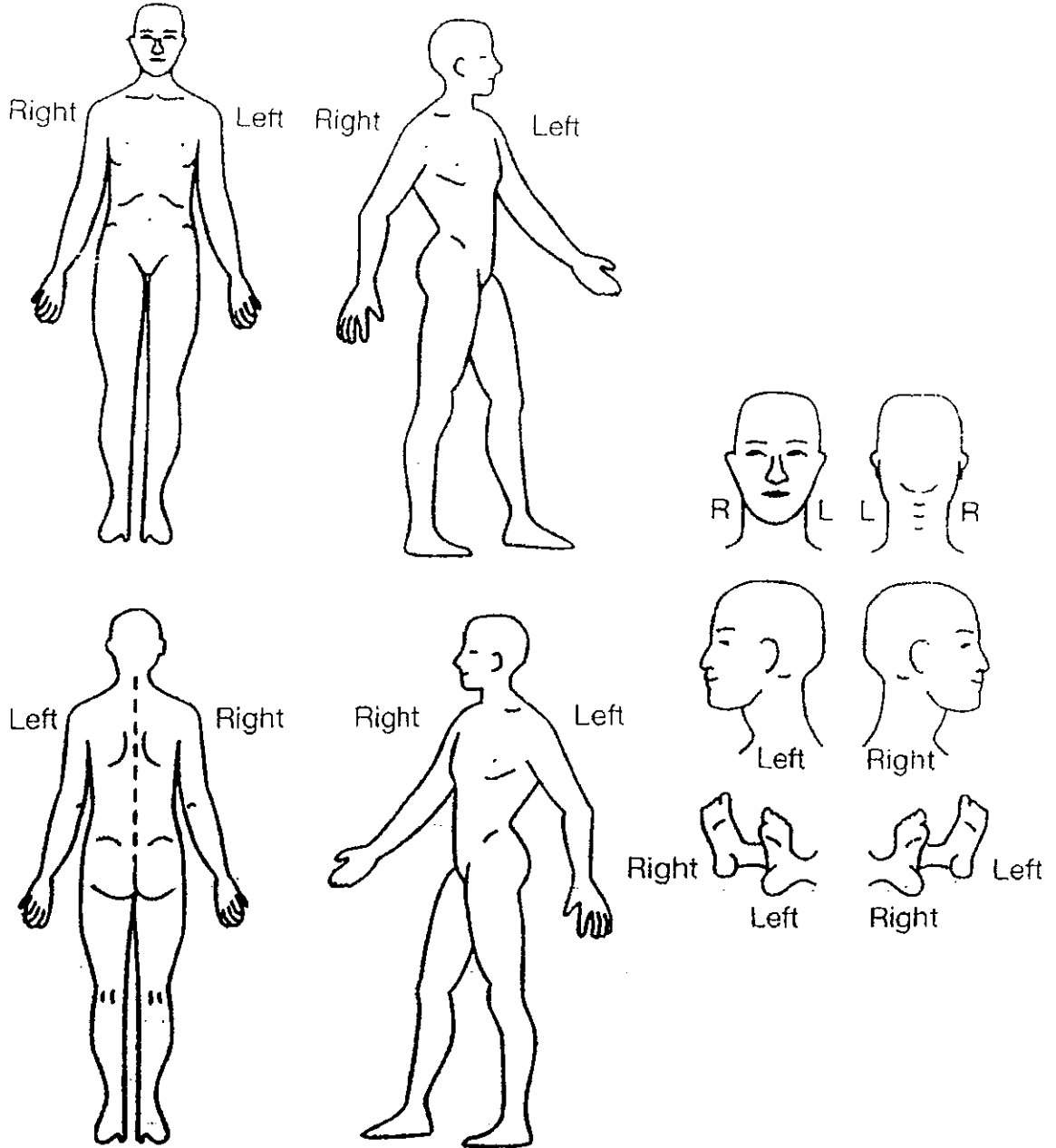
Name/ Relation



PAIN DIAGRAM

Name: _____ Date: _____

Using the diagram below, please indicate where your pain is located (using XXX):



VS: HT: _____ WT: _____ Pulse: _____ Resp: _____ Temp: _____

SERVICES PROVIDED

Onsite Massage/Physical Therapy (MM20830)
 Neuro and Post-Surgical Rehabilitation
 Wellness & Exercise Fitness Programs

Sports / Auto Accidents Injuries
 DRS Lumbar Spinal Decompression
 Dizziness & Fall/Balance Testing & Rehab

EMG/Nerve Conduction Studies
 IME's/ Impairment Ratings
 Therapeutic Botox Injections

MEDICAL QUESTIONNAIRE

Completing this questionnaire will assist your physician in diagnosing your complaints and in developing the appropriate plan of care. Put N/A after questions not applicable to you. Thank you.

NAME: _____

Today's date: _____

Sex: Male Female Age: _____ Right Handed Left Handed

1. What is your **chief complaint**?

- Frequently (1/2 of the day)
- Constantly (all day)

2. What are your **secondary complaints**?
a) _____
b) _____
c) _____

13. Please describe your secondary complaint (question #2)
- burning throbbing shooting
 - stabbing sharp dull
 - achy tight sore
 - Other: _____

3. How long have you had this problem?

14. What makes your secondary complaint (question #2) worse:
- sneezing lifting sitting
 - standing bending leaning
 - stress Other: _____

4. Are your injuries secondary to:
 a work related injury (date: _____)
 a motor vehicle accident (date: _____)
 a slip and fall accident (date: _____)
 other: _____

15. What makes your secondary complaint (question #2) better:
- ice/heat rest stretching
 - medications Other: _____

5. Did you have similar complaints in the past? (Explain)

6. List the doctors you have seen for your condition:

TREATMENT HISTORY

16. Please check all **treatments** you have received:
- Injections (Type: _____)
 - Chiropractic Manipulation
 - Physical Therapy
 - Massage
 - Psychotherapy/Psychiatric Care
 - Traction
 - Others: _____
- Which of the treatments above were the most helpful:

7. Is your pain getting: Worse Better Same

8. What is your usual level of pain (10: highest):
0 1 2 3 4 5 6 7 8 9 10

8. Is your **chief complaint** (question #1) affecting you:
 Occasionally (less than 1/3 of the day)
 Frequently (1/2 of the day)
 Constantly (all day)

17. What medications have you tried for your pain:

9. Please describe your chief complaint (question #1)

- burning throbbing shooting
- stabbing sharp dull
- achy tight sore
- Other: _____

18. Which medications were the most helpful:

10. What makes your chief complaint (question #1) worse

- sneezing lifting sitting
- standing bending leaning
- stress walking Other: _____

FUNCTIONAL STATUS

19. What is your current **occupation**?

11. What makes your chief complaint (question #1) better

- ice/heat rest stretching
- medications Other: _____

20. What are the primary **activities you do at work**:
- sitting squatting bending
 - kneeling reaching typing/writing
 - lifting 1-10 lbs lifting 11-20 lbs
 - lifting 21-50 lbs lifting 51-100 lbs
 - lifting over 100 lbs

12. Is your **secondary complaint** (question #2) affecting you:
 Occasionally (less than 1/3 of the day)

21. Has your pain affected your other **functions**?
- self care travel household chores

- sleep sports hobbies
- school sexual function
- Other: _____

PAST MEDICAL HISTORY

22. Please list any x-rays, CT-scan, MRIs, NCS, and what the significant findings were:

23. Please check any personal history of:

- Cancer Ulcers Anemia
- Reflux Clots Infections
- Diabetes Depression High blood pressure
- Asthma Liver disease Thyroid disease
- Heart disease Addiction Alcoholism
- Other: _____

24. List any **surgeries** that you have had in the past:

25. List any **major accidents** (car accidents, fractures or work-related injuries). Please give dates.

FAMILY MEDICAL HISTORY

26. Check any illnesses in your family (blood relatives):

- Diabetes Cancer High blood pressure
- Stroke Arthritis Thyroid disease
- Heart attacks Alcoholism Addiction
- Other: _____

MEDICATION HISTORY

27. List all **medications** you are currently taking (prescribed and over the counter). Please include vitamins, herbs or supplements:

28. Are you **pregnant** or do you plan to become pregnant?

- Yes (discontinue all medications unless advised otherwise by your physician)
- No.

29. List any drug **allergies** and describe your reaction:

SOCIAL HISTORY

30. Please answer the following questions about your social history:

- Status: Married Single Divorced Separated
- Smoker: No Yes, _____ packs per day
- Drugs: No Yes, Type: _____
- Alcohol: No Yes, _____ drinks per week

If yes, please answer the following four questions:

a. Have you ever felt you should cut down on your drinking? Y / N

- b. Have people annoyed you by criticizing your drinking? Y / N
- c. Have you ever felt bad or guilty by drinking? Y / N
- d. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Y / N

REVIEW OF SYSTEMS

31. Please check if you have any of the following:

- weight loss fevers/chills night sweats
- weakness fatigue skin/nails problems
- hair loss blurry vision ringing in the ears
- vertigo earache nosebleeds
- nausea vomiting difficulty swallowing
- hoarseness chest pain abdominal pain
- kidney stones anemia easy bruising
- easy bleeding seizures incontinence
- depression anxiety difficulty walking
- insomnia constipation diarrhea
- dizziness loss of balance memory problems

32. Primary Care Physician's Name and Address:

33. Do you want us to send a copy of your report(s) to your primary care physician? Yes No

PERSONAL INJURY HISTORY

If your injuries are due to a **motor vehicle accident**, please answer the additional questions:

Where you: the driver passenger of the vehicle?

Type of vehicle (make/model): _____

Was your vehicle: at a stop moving at _____ mph

Describe how the accident happened: _____

Were you wearing your seat belt? Yes No

Vehicle was struck: Head-on Rearended Side

On impact: braced w/ arms on steering wheel

braced w/ legs on floor or brakes

Did you strike any part of your body? If yes, against what

Any loss of consciousness? No Yes, _____ minutes

Did you feel: dizzy confused scared nervous

Immediate symptoms: _____

Subsequent symptoms: _____

Were you evaluated by paramedics No Yes

Were you taken to the hospital? No Yes

If yes, which hospital? _____

Type of emergency treatment (medications, x-rays, sling): _____



Release of Records Authorization
Authorization to obtain, release or review protected Health Information

I, _____ hereby authorize Dr. Pedro T. Oliveros' office to obtain records.

From: _____
(Doctor or Hospital releasing information)

Address: _____

Telephone # _____ Fax # _____

This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained except to the extent that the action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulation. I understand that I may select the information from the list below to be released by placing a check mark or an "x" in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information.

I hereby authorize and request the above named to release:

- The complete medical history
- Diagnostic Tests: X-ray/ MRI / CT-SCAN / EMG- NCS, ETC.
- Doctors last notes
- Records of treatment during the period of _____ to _____
- Labs only
- Other: _____

Patient Name: _____

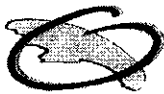
Date of Birth: _____ Social Security # _____

Records should be sent to:

- Maitland Office:** 341 N. Maitland Avenue Suite 200 Maitland FL 32751 Tel # (407)-265-2100 *
Fax (407)-265-2872

Patient's Signature: _____

Date: _____



PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Pedro T. Oliveros, MD, PT
Medical Director

Important Company Policies

We strive to provide you with the best, personalized care available. To do so, we adhere strictly to the policies below. Please read them carefully, initial all the boxes, and indicate your understanding and agreement by signing at the bottom.

- Late Policy**
Being late **by more than 10 minutes** requires you to either reschedule or wait for the next available opening. We do not allow appointment overlap because this compromises patient care.
- Appointment Change or Cancellation Policy**
If you wish to **change** or **cancel** an appointment, we require a minimum **24-hour advance notice**. Anything less will result in a **\$25 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not, we still accrue expenses for staff wages, rent, etc. Advance notice allows someone who needs care to reserve the time in place of you. Please be courteous and responsible.
- No Show Policy**
If you fail to show for an appointment without notice, a **\$25 fee** will be charged to your account. You may re-schedule appointments again on a "first come, first serve basis". If two consecutive appointments are missed with no notice all future appointments will be cancelled.
- Co Pays are due upon arrival**
If you forget your wallet or checkbook, you will need to complete of an "Extension Request" form. This *promise-to-pay* carries an additional **\$10 fee** and is payable on your next appointment or within 14 days, which ever comes first.
- Children requiring supervision are NOT allowed to attend sessions with you**
If your child does not require supervision and is capable of waiting for you quietly, you may bring them. If any disturbance is caused to other patients or staff members, you may be asked to terminate your session early and attend to your child.
- Financial Hardship**
If you qualify for financial assistance under federal standards, we may be able to waive the portion of the charges you are responsible for as outlined in your insurance plan. If however, you are enrolled in a Medicare or other federal government funded health insurance program, we must follow federal regulations regarding co-payments. Alternate agreements could be seen as a violation of the Stark Anti-Kickback Law. For more information: Office of Inspector General, Department of Health and Human Services 333 Independence Avenue, S.W. Washington, D.C. tel. 202-619-1343 or 202-619-0089, fax 202-260-8512, email paffairs@oig.hhs.gov

Ask the front desk for the Financial Hardship form.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

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