Strive!
HEALTH & REHABILITATION

New Patient Registration Form

Last Name:_____ First Name:_____ M.I._____

Mailing Address:_____

City:_____State:_____ Zip:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

Date of Birth:_____/_____/_____ Date of Injury: _____/_____/_____

Sex: ☐ Male ☐ Female ☐ Other **Marital Status:** ☐ Single ☐ Married ☐ Other

Email Address:_____

▫ I consent to receive emails from Strive! ▫ I DO NOT consent to receive emails from Strive!

How did you hear about us:

☐Doctor ☐Friend/Relative ☐Advertising ☐Facebook/Internet ☐Community Event

☐ Hospital ORMC/WMCH ☐Other:_____

Employer/Company:

Name:_____Occupation: _____Phone:(_____)_____

Emergency Contact:

Name:_____Relationship: _____Phone:(_____)_____

Estimated Financial Responsibility

Based on the information provided the following is an **ESTIMATE** of your financial responsibility.

Copay:$_____ CoInsurance:_____% Self Pay:$_____ Other:_____

_____ _____

Patient or Guardian Signature Date

Consent For Examination & Treatment

I hereby consent to examination and treatment as deemed necessary by Strive! and its providers for the management of my condition(s).

Like most health care procedures they carry with it some risks. Unlike many such procedures, the serious risks associated are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It common for patients to experience temporary soreness or increased symptoms or pain after the first few treatments as your body heals. It is important to notify your provider if symptoms change or worsen.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the provider if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, such as osteoporosis or osteopenia, they may be susceptible to fracture. It is important to notify your provider if you have been diagnosed with a bone weakening disease or condition. If your provider detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or disc herniations may worsen even with care. It is important to notify your provider if symptoms change or worsen.

Other risks associated with treatment include rare burns from physiotherapy devices that produce heat such as ultrasound and electrical muscle stimulation.

For Chiropractic Patients: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

For Pain Management: I authorize Strive! and it's employees to perform services and any minor procedures such as, muscle and spinal injections as well as, EMG procedures on my behalf, as deemed necessary.

I understand that this treatment, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.
I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with treating providers and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

_____ _____

Patient or Guardian Signature Date

NOTICE OF PRIVACY PRACTICES & HIPAA

In accordance with the **Health Insurance Portability and Accountability Act (HIPAA)**, patients of Strive! are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's **Protected Health Information (PHI)** may only be released as authorized by this law. Strive! will follow HIPAA guidelines to ensure patient information is used only for purposes authorized by the patient, including but not limited to: patient treatment, payment operation, lawful subpoenas, and as otherwise required by law.

Upon providing reasonable advance notice, patients have a right to review their medical records and furnish comments to their records during normal business hours. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described in our Notice of Privacy Practices unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice is effective 05 December 2016

This Notice of Privacy Practices applies to the following organizations:

Strive! Physical Therapy Centers
2620 SE Maricamp Rd
Ocala, FL 34471
(352) 351-8883
Official: Randal Halter, DPT

Strive! Integrative Physical Medicine
2626 SE Maricamp Rd
Ocala, FL 34471
(352) 351-8883
4600 SW 46th Ct #140
Ocala, FL 34474
(352) 873-3058
Official: Ella Meach, COO

_____ _____

Patient or Guardian Signature Date

Financial Policies & Insurance Program

At Strive! we are committed to providing you with exceptional care. Please understand that payment for services rendered to you are part of our agreement. Our self-pay and/or insurance assignment program is designed to keep your out of pocket expenses to a minimum. As a courtesy, Strive! will bill your insurance carrier on your behalf and wait up to 60 days for payment from your insurance company. Strive! will verify your insurance benefits and inform you of what your plan covers. This is not a guarantee of payment from your insurance company. Please remember that you are ultimately responsible for payment for services provided to you or your dependent. Strive! will work with your insurance company to secure payment on your behalf but sometimes your assistance is needed.

Under your health care plan, you are financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include, but is not limited to: vitamins & supplements, durable medical equipment and wellness / maintenance care.

An estimated patient copay/coinsurance/deductible amount will be collected from you at the time of service(s). Once your insurance finalizes your claim, Strive! will know your exact out-of-pocket expense and apply your co-pay/co-insurance to your account accordingly. This may leave your account with a credit or you may have a balance. If you have a balance for your services rendered, you will be invoiced and payment is expected within fourteen days.

By my signature below, I acknowledge that I have been advised of the above guidelines and agree to these guidelines. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that parents or legal guardians are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or my dependent. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges. Furthermore, I understand it is my responsibility to pay any deductible amounts, copays, co-insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. In the event I receive my payment from my insurance carrier, I agree to endorse any payment over to Strive! for which services are payable. If my account is assigned to an attorney for collection, the prevailing party shall be entitled to reasonable attorney's fees and costs of collections. I understand there is a $25 fee for all returned checks.

Assignment of Benefits & Release of Medical Records

I, the undersigned, certify that I (or my covered dependents) have insurance coverage with: _____ and assign directly to Strive! and it's physicians all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for my services regardless if they are a covered benefit or not. I hereby release Strive! and it's physicians to release all PHI information concerning my relevant medical history to other healthcare providers involved in my care, my insurance company, insurance adjustor and my attorney to secure payment for my services. I authorize the use of this signature on all insurance claim submissions for my services. An electronic copy of this authorization and agreement shall be valid as the original.

_____ _____

Patient or Guardian Signature Date

Photographic Medical Release Form

☐I hereby consent to the use of my photograph in my electronic health record. The photograph may be taken by one of the Strive! medical staff and if taken will become a part of my electronic health record. My photograph is to be used for the purpose of identification and will only be found in Strive! electronic health software and on my patient portal. I understand my photograph will not be copied or transferred outside of my electronic health record.

☐I do not consent to my photograph being taken.

Photographic Advertisement Release Form

☐I grant permission to Strive and its agents and employees right to reproduce the photographs and/or video images taken of me for the purpose of publication, promotion, illustration, advertising, in any manner or in any medium. I hereby release Strive and its legal representatives for all claims and liability relating to said images or video. Furthermore, I grant permission to use my statements that were given during an interview or guest lecture, with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

☐I do not consent to my photograph being taken.

_____ _____

Patient or Guardian Signature Date

Medical Records & Billing Disclosures to Individuals Involved in Your Care

There may be times when it is necessary for an individual directly involved in your care to call our office to inquire about your personal health information (PHI) or billing information.

By my signature below, I authorize Strive! Medicine to disclose my health information that is directly related to my current treatment at Strive! to the individual(s) listed below for purposes of his / her role in my treatment or payment for the services I receive at Strive.

Name	Relationship	Phone Number

_____ _____

Patient or Guardian Signature Date

Strive!
HEALTH & REHABILITATION

Name: _____ DOB: _____

Occupation: _____ Leisure Activity: _____

Allergies: _____

Are you latex sensitive? **YES NO** Do you have a pacemaker? **YES NO**

Do you have an Advanced Directive or Do Not Resuscitate? **YES NO**

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS:

YES NO Cancer; What Kind: _____

YES NO Heart Problems

YES NO High Blood Pressure

YES NO Circulation Problems

YES NO Asthma

YES NO Emphysema/Bronchitis

YES NO Chemical Dependency

YES NO Thyroid Problems

YES NO Diabetes

YES NO Multiple Sclerosis

YES NO Rheumatoid Arthritis

YES NO Other Arthritic Conditions

YES NO Depression

YES NO Infectious Diseases

YES NO Tuberculosis

YES NO Stroke, TIA

YES NO Kidney Disease

YES NO Anemia

YES NO Epilepsy

YES NO Other

During this month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been having little interest in doing things? **YES NO**

Do you ever feel unsafe at home or has anyone injure you in anyway? **YES NO**

FOR WOMEN: Are you currently pregnant or think you may be pregnant? **YES NO**

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED (Including Date):

_____ _____ _____

_____ _____ _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:

YES NO Weight Loss/Gain

YES NO Nausea/Vomiting

YES NO Fatigue

YES NO Weakness

YES NO Fever/Chills

YES NO Numbness/Tingling

_____ _____

Patient or Guardian Signature Date

PLEASE LIST ANY HEALTHCARE PROVIDERS YOU ARE CURRENTLY SEEING AND THE REASON:

_____ _____ _____

_____ _____ _____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (PARENTS, BROTHER, SISTER) EVER BEEN TREATED FOR:

YES NO Diabetes

YES NO Tuberculosis

YES NO Heart Disease

YES NO High Blood Pressure

YES NO Stroke

YES NO Kidney Disease

YES NO Chemical Dependency

YES NO Cancer

YES NO Arthritis

YES NO Anemia

YES NO Headaches

YES NO Epilepsy

YES NO Mental Illness

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER, CREAMS, PATCHES AND INJECTIONS:

_____ _____ _____

_____ _____ _____

Do you consume caffeine? **YES NO** How many do you drink a day? _____

Do you smoke? **YES NO** How many packs you smoke a day? _____

Do you drink? **YES NO** How many days per week do you drink? _____

PLEASE DESCRIBE ANY INJURIES WHICH YOU HAVE BEEN TREATED AND THE APPROXIMATE DATE:

_____ _____ _____

_____ _____ _____

_____ _____

Physician Signature Date

_____ _____

Patient or Guardian Signature Date

Strive!
HEALTH & REHABILITATION

Medicare with Secondary Payer Questionnaire

Patient Name:_____ **Date of Birth:** _____/_____/_____

1. Have you had any Home Health Care in the last 60 days? YES NO

Home Health Agency: _____ Date Discharged: _____/_____/_____

2. Was your illness/injury due to any of the following:

_____ **Not Applicable**

_____ **Work Related** Date of Accident: _____/_____/_____

_____ **Automobile Accident** Date of Accident: _____/_____/_____

_____ **Accident on Property (Other than your own)**
Date of Accident: _____/_____/_____

***Do you intend to file a liability claim or lawsuit in connection with this injury?**
YES NO

Attorney Information:

Attorney Name:_____

Law Firm: _____

Phone: (_____) _____ City, State: _____

3. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility?
YES NO

4. Have you received a kidney transplant or on dialysis? YES NO

Date of Transplant:_____/_____/_____

5. Do you have group insurance coverage through a family member's employer?
YES NO

_____ _____
Patient or Guardian Signature Date