PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Pedro T. Oliveros, MD, PT
Medical Director

Patient Information

Name _____ _____ _____ Sex: Male ☐ Female ☐
Last *First* *M*

Address _____ _____ _____ _____ _____ _____
Street *Apt* *City* *St* *Zip*

Phone (____) _____ - _____ (____) _____ - _____ Email _____
Primary *Secondary*

Social Security # _____ - _____ - _____ Date of Birth ____/____/_____ Marital Status: Single ☐ Married ☐ Other ☐

Emergency Contact _____ (____) _____ - _____ _____
Name *Phone* *Relationship*

Primary Care Physician _____ Phone: (____) _____ - _____

How did you find out about us? _____

Please read carefully, the following i**mportant information**:

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.

Keeping your scheduled office visits and physical therapy appointments is the part of your recovery process that **you** control. We cannot help you if you miss your scheduled appointments.
*A **$50** fee will be billed to your account if you do not notify us at least 24 hours prior to your scheduled appointments.
*If two consecutive appointments are missed, all scheduled appointments will be cancelled.
*The fee will be increased to **$75** for all future appointments cancelled without 24-hour prior notice.

Children requiring supervision may NOT attend sessions with you. If you do bring your child, and he/she causes a disturbance, you may be asked to terminate your session early.

If pre-authorization is required by your insurance plan, we will send the initial request and necessary medical records for your medications. However, if it is denied, we will not appeal their decision. Medications allowed are based on your insurance coverage. You are responsible for follow up with your Pharmacy Benefit Manager. **Please initial here**:_____

We are required by Florida Law to randomly perform drug testing for patients who are prescribed narcotics or opioids; a $15 fee is payable upon testing or will be charged to your account and is payable prior to your next office visit. Failure to provide samples will result in discharge from the practice.

Patient is responsible for all medical bills submitted for service rendered and, payment is not contingent on payment by an insurance company, judgment or verdict to which you may be entitled. A finance charge of 1.5 % per month (annual percentage rate 18%) will be added monthly to the unpaid balance. Should collection become necessary, court costs and legal fees will be added.

Co-pays are due upon arrival. If you are unable to make payment at time of service, 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, whichever comes first.

If you are **represented by an attorney,** you are still responsible for payment of fees for services rendered. In consideration for accepting my attorney's Letter of Protection, I also give you a Lien against the proceeds of any settlement, judgment or verdict which I may be entitled to.

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

_____ _____
Patient Signature or Legal Representative Printed Name and Signature *Date*

341 N. Maitland Avenue, Suite 200, Maitland, FL 32751 tel 407-265-2100 fax 407-265-2872

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

Privacy Policy (Effective April 14, 2003)

Background

Medical offices are required by federal and state laws to maintain confidentiality of medical information generated for patients during their course of treatment. Legislation requires patients to be notified about privacy practices, our legal duties concerning these practices, and your rights concerning your health information. Our goal is to maintain confidentiality of your medical information. There are times, however, when identifiable health information must be disclosed to specific entities such as your insurance carrier. In these cases, we will only disclose information essential to comply with the request.

We reserve the right to change our policy related to health information collected and maintained, including information obtained before policy changes were determined to be necessary. As changes in our privacy practices are made, we will notify our patients of these changes.

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.
- when we are required to do so by law through a subpoena.
- to military authorities under certain circumstances
- to correctional institutions or law enforcement officials having lawful custody of protected information of inmates or patients under certain circumstances.

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.

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 will be charged our customary fee for responding to these requests.
- You have the right to request that we communicate with you regarding your medical information or treatment; any such requests must be in writing.
- You have the right to request that we amend the 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.

Below please enter names of individuals you would like to disclose any medical information in person

_____ _____
Name / Relation Name / Relation

_____ _____
Patient Signature or Legal Representative Printed Name and Signature Date

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PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

Authorization for Release of Records

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 re-disclosure of my health information.

I hereby authorize and request the above named to release the following:

- ❑ 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:_____

Please fax records to:
Physical Medicine & Rehab Center of Orlando
407-265-2872

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature or Legal Representative Printed Name and Signature Date

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

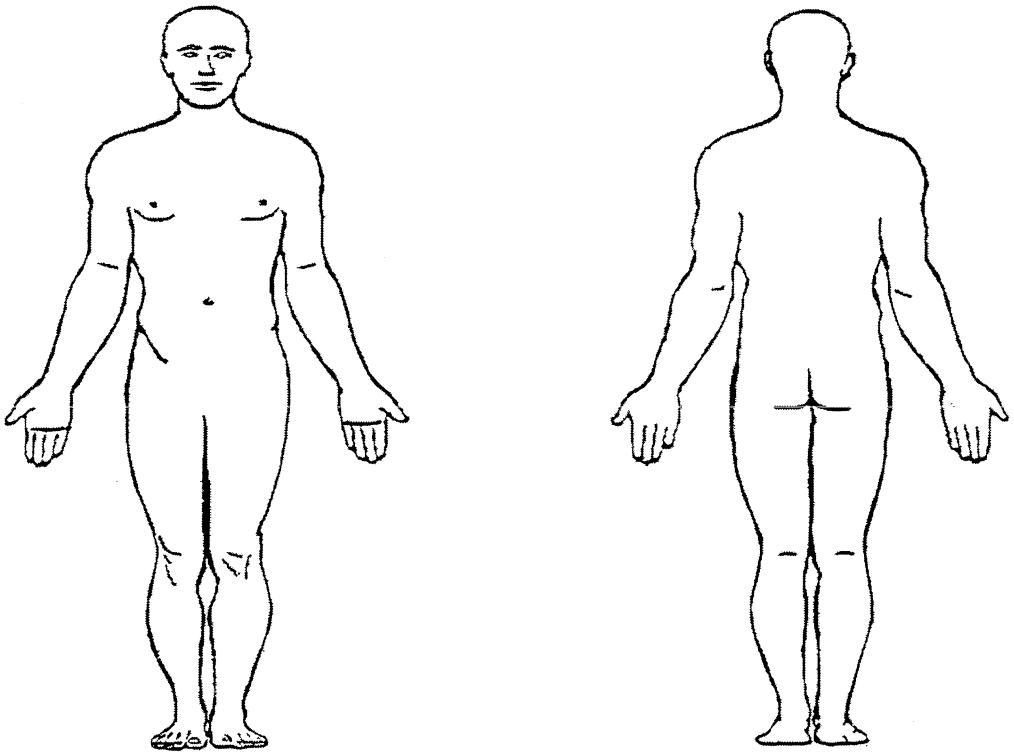
Pain Diagram

Name _____ Date _____

Mark the drawings below **where** you feel pain.

Please indicate ***which*** sensations you feel by referring to the key below

Burning XXXX Pins & Needles 0000 Numbness ==== Aching ++++ Stabbing ////



Consent for Treatment

Our office focuses on active rehabilitation programs to control or minimize your pain with the goal of maximizing your function. It is generally accepted that multidisciplinary treatment of chronic pain leads to best outcomes. Your compliance with this multidisciplinary approach (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. Our goal is to minimize or taper off the use of medications as you recover. Too much reliance on pain medication or not showing up for your rehab visits consistently will not be tolerated. **Any unethical or aberrant behavior diversion, (selling opioids to others, taking opioids for emotional reasons, "doctor shopping', taking illicit substances, sharing medications, not taking opioids as prescribed, etc.) will be grounds to be discharged from our care**.

The undersigned hereby **consents** to the provision of examination, fitness evaluation, treatment, therapies, medical and laboratory procedures, and drugs and supplies by the healthcare providers of Pedro T. Oliveros Jr., MD, PA 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 Signature or Legal Representative Printed Name and Signature Date

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PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO

Pedro T. Oliveros, MD, PT
Medical Director

Medical Questionnaire

Name _____ **DOB** _____ **Todays date** _____

1. What is your chief complaint?

_____

_____

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

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

4. Please describe your chief complaint:
☐ burning ☐ throbbing ☐ shooting
☐ stabbing ☐ sharp ☐ dull
☐ achy ☐ tight ☐ sore
☐ Other: _____

5. What makes your chief complaint worse?
☐ sneezing ☐ lifting ☐ sitting
☐ standing ☐ bending ☐ leaning
☐ stress ☐ walking ☐ Other: _____

6. What makes your chief complaint better?
☐ ice/heat ☐ rest ☐ stretching
☐ medications ☐ Other: _____

7. How long have you had this problem?

_____

8. Have you had a similar problem in the past? (Explain)

_____

_____

9. Are your conditions from:
☐ a work related injury (date: _____)
☐ a motor vehicle accident (date: _____)
Where you: ☐ the driver ☐ passenger of the vehicle?
Was your vehicle: ☐ at a stop ☐ moving _____mph
Were you wearing your seat belt? ☐ Yes ☐ No
Vehicle was struck: ☐ Head-on ☐ Rear ☐ Side
Loss of consciousness? ☐ No ☐ Yes, _____minutes
Were you taken to the hospital? ☐ No ☐ Yes
If yes, which hospital? _____
☐ a slip and fall accident (date: _____)
☐ other: _____

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

_____

_____

May we send a copy of your report(s) to your primary care physician? ☐ Yes ☐ No

11. Describe any other problems: _____

_____

_____

TREATMENT HISTORY

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

_____

_____

13. Please check all treatments you have received:
☐ Injections (Type: _____)
☐ Chiropractic Manipulation
☐ Physical Therapy
☐ Massage
☐ Psychotherapy/Psychiatric Care
☐ Traction
☐ Medications: _____
☐ Others: _____

PAST MEDICAL HISTORY

14. 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: _____

15. 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 ☐ memory problems

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

_____

_____

FAMILY MEDICAL HISTORY

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

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

MEDICATION HISTORY

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

_____

_____

_____

19. Are you pregnant or do you plan to become pregnant?
☐ Yes (discontinue all medications unless advised otherwise by your physician)
☐ No.

20. List any drug allergies and describe your reaction:

_____

_____

SOCIAL HISTORY

21. What is your current occupation?

_____

22. 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

23. Has your pain affected your other functions?

☐ self-care ☐ travel ☐ household chores
☐ sleep ☐ sports ☐ hobbies
☐ school ☐ sexual function
☐ Other: _____

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
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

24. 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 1 hr 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

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July 18, 2012

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

Patient: _____ **Date:** _____

OPIOID RISK TOOL (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction

Mark each box that applies.

	Female	Male
1. Family History of Substance Abuse:		
Alcohol	❑	❑
Illegal drugs	❑	❑
Prescription drugs	❑	❑
2. Personal History of Substance Abuse:		
Alcohol	❑	❑
Illegal drugs	❑	❑
Prescription drugs	❑	❑
3. Age (mark box if between 16 and 45)	❑	❑
4. History of Preadolescent Sexual Abuse	❑	❑
5. Psychological Disease		
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	❑	❑
Depression	❑	❑
Scoring Totals	_____	_____

341 N. Maitland Avenue ♦ Ste. 200 ♦ Maitland FL 32751 ♦ PH: 407-265-2100 ♦ FX: 407-265-2872
www.pmrc*Orlando*.com

PHYSICAL MEDICINE & REHAB CENTER OF ORLANDO
Pedro T. Oliveros, MD, PT
Medical Director

Assignment of Benefits

I, _____ assign, to Physical Medicine & Rehab Center of Orlando all rights,
Name of Patient / Guardian
claims, benefits and causes of action for personal injury protection and medical payment benefits available to me under

the policy issued by _____ to _____ for medical claims
Insurance carrier **Policy Holder**
resulting from an automobile accident which occurred on _____.
Date of Accident

Patient Signature_____ Date_____

The undersigned hereby accepts assignment of insurance benefits for services to _____ and to be paid directly to Physical Medicine & Rehab Center of Orlando under the personal injury protection and/or medical payment benefits coverage with _____ and in accordance with the Florida Statute 627.736(5)

Representative_____ Date_____

PIP Log Request

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to 627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorized this Assignee to request and receive a copy of my pip log periodically as they deem to be necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Patient Signature_____ Date_____

Reservation of Benefits

Be further advised that I am hereby placing you on notice pursuant to Florida case law that should you _____(insurance carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provider, I_____, and assignee Physical Medicine & Rehab Center of Orlando are requesting in advance that you reserve, or "act-aside, the amount you reduced or deny until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payment as "Full and Final Payment," I have instructed this health care provider to return the check to you (the Carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S 627.736). Additionally should the remaining amount of my benefits approach an amount where there would be inefficient funds to pay the amount you reduced, denied or failed to pay, please notify me (the assignor) and the assignee, Physical Medicine & Rehab Center of Orlando of this fact. Lastly, should my benefits become exhausted; please notify me (the assignor) and this health care provider, Physical Medicine & Rehab Center of Orlando

Patient Signature_____ Date_____

Print Name_____

Address_____ City_____ St_____ Zip_____

_____ _____
Legal Representative Printed Name and Signature Date

341 N. Maitland Avenue, Suite 200, Maitland, FL 32751 tel 407-265-2100 fax 407-265-2872

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**

   _____

   _____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.