



MULTI-DISCIPLINARY TREATMENT CENTERS
24945 US Hwy 19 N, Clearwater, FL 33763 PH: 727-726-1460
1001 37th St. N., Suite D, St. Petersburg, FL 33716 PH: 727-914-9130
667 W. Lumsden Rd., Brandon, FL 33511 PH: 813-867-7323

New Patient Intake

\*Please see the front desk if your visit today is related to an auto accident or work-related accident.\*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F Marital Status M D W S

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

The listed information will be used to supply patient health information. Emails from staff are not encrypted.

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Persons you want to have access to your medical information. Due to HIPAA regulations we will not be able to release information to those not listed:

Name & Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name & Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name & Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Information:

Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Claim Number if using Auto, Work Comp, Etc.: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB of Insured: \_\_\_\_\_

Relationship to Insured: Self Spouse Parent Other \_\_\_\_\_

Claims Billing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Adjuster/Case Manager: \_\_\_\_\_

Accident Information: Circle One: Work Related / Auto Accident / Slip & Fall

Date of accident/injury: \_\_\_\_\_ Has the accident/injury been reported to work/insurance? \_\_\_\_\_

If work related, Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If Slip & Fall; where did the incident happen? \_\_\_\_\_

Did accident/injury occur in the State of Florida? \_\_\_\_\_ If "No" where did it occur? \_\_\_\_\_

Is there an attorney involved? \_\_\_\_\_ If "Yes" Name: \_\_\_\_\_

Did you go to the hospital? \_\_\_\_\_ If "Yes" Hospital Name/Location: \_\_\_\_\_

By signing below, I attest that all information supplied today is true and valid to the best of my knowledge. I have been given a copy of Total Vitality Medical Group's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Total Vitality Medical Group LLC has the right to change this Notice at any time. I may obtain a current copy by contacting the office.

Patient/Guardian Signature

Date



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**Patient Health History Form (Page 1)**

<b>Name</b>	<b>Date of Birth</b>	<b>Today's Date</b>
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Age</b>		
<b>Currently Living</b> <input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> With Friends <input type="checkbox"/> With Significant Other <input type="checkbox"/> Retired		

**Medical History**

<b>Check(C) for current medical complaint</b>	<b>Check (P) for past medical complaint</b>	
<b>C P</b>	<b>C P</b>	<b>C P</b>
<input type="checkbox"/> <input type="checkbox"/> Arthritis or Sore Joints	<input type="checkbox"/> <input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> <input type="checkbox"/> Alcoholism
<input type="checkbox"/> <input type="checkbox"/> Anemia or Low Blood	<input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> Asthma or Hay Fever
<input type="checkbox"/> <input type="checkbox"/> Bronchitis or Emphysema	<input type="checkbox"/> <input type="checkbox"/> Bleeding or Bruising	<input type="checkbox"/> <input type="checkbox"/> Broken Bones
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Circulation Problems	<input type="checkbox"/> <input type="checkbox"/> Cataracts
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Deafness or Dizziness or Ringing Ears	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Difficulty Sleeping or Lie Awake
<input type="checkbox"/> <input type="checkbox"/> Ear Infections	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> Gout
<input type="checkbox"/> <input type="checkbox"/> Gall Stones	<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	<input type="checkbox"/> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Hepatitis Type A, B or C	<input type="checkbox"/> <input type="checkbox"/> Headaches (Frequent)
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Hernia
<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Kidney or Bladder Problems	<input type="checkbox"/> <input type="checkbox"/> Leg or Foot Pain
<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Phlebitis or Blood Clots	<input type="checkbox"/> <input type="checkbox"/> Night Sweats
<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> STD	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Skin Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Stomach Problems or Ulcers	<input type="checkbox"/> <input type="checkbox"/> Stool or Bowel Problems	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis or Positive TB Test		

<b>Female Patients: Are you pregnant or could be pregnant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you Menstruate</b> <input type="checkbox"/> Yes <input type="checkbox"/> No – <b>Last Menstrual Cycle:</b>
<b>Are you on Birth Control:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Number of Pregnancies:</b> _____ <b>Vaginal Birth</b> <input type="checkbox"/> <b>Caesarean Section</b> <input type="checkbox"/>

**Habits**

<b>Do you:</b>	<b>If Yes, how much?</b>		
Smoke Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	Packs/Day _____	Chew Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes Tins or Bags/Day _____
Drink Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cups/Day _____	Drink Beer <input type="checkbox"/> No <input type="checkbox"/> Yes Cans/Day _____
Drink Alcohol or Wine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drinks/Day _____	Gamble <input type="checkbox"/> No <input type="checkbox"/> Yes
Use Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes		Exercise <input type="checkbox"/> No <input type="checkbox"/> Yes

**Medications**

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)


**Immunizations**

MMR	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Hepatitis B	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Tetanus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____
Flu Shot	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date _____

**Allergies** (medications, foods, bee sting, etc. and your reaction)

1.	Reaction: _____
2.	Reaction: _____
3.	Reaction: _____
4.	Reaction: _____
5.	Reaction: _____

**Hospitalizations** (not including normal pregnancies)

1.	Year: _____
2.	Year: _____
3.	Year: _____
4.	Year: _____
5.	Year: _____



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**Family History (Page 2)**

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

Check Yes or No if any of your family member(s) have ever had any of these medical issues. If you answer yes, please provide the relationship of the family member e.g. mother, father etc.

Alcoholism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Leukemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Liver Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Asthma or Hay Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Mental Illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Birth Defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Migraines	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Nervous Breakdown	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Colon or Bowel Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Obesity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Congenital Heart Defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Rheumatic Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Sickle Cell Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Stomach Ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

**Review of System**

**CHECK ANY RECENT HEALTH ISSUES:**

**Overall health:** No Abnormality Fever Chills Fatigue

**Weight:** Large Weight Gain Large Weight Loss

**Eyes:** No Abnormality Vision Changes

**HENT (Head, Ears, Nose, & Throat):** No Abnormality

Sinus Pain Sore Throat Nasal Discharge Headaches Thyroid Mass  
Dental Problems Sinus Congestion Dizziness Fainting

**Breasts:** No Abnormality

Nipple Discharge Lumps Pain Swelling Redness

**Cardiovascular:** No Abnormality

Rapid Heart Rate Varicose Veins Chest Pain Irregular Heart Beats

**Respiratory (Lungs & Breathing):** No Abnormality

Shortness of Breath Cough Wheezing

**Gastrointestinal:** No Abnormality

Abdominal Pain Nausea Vomiting Diarrhea Constipation  
Loss Of Appetite Hemorrhoids Blood In Stool Heartburn Reflux

**Genitourinary (Genitals, Urinary Tract & Kidneys):** No Abnormality

Blood Clots w/ Menses Pelvic Pain Vaginal Discharge Pain w/ Intercourse  
Vaginal Itching Genital Sores PMS (Premenstrual Syndrome) Vaginal Odor  
Frequent Urination Vaginal Dryness Vaginal Burning Decreased Sex Drive (Libido)  
Genital Swelling Possible Pregnancy Irregular Menses Missing Menses (Amenorrhea)  
Pain w/ Urination Heavy Menses Painful Menses Incontinence  
Urgent Urination Blood In Urine Pain From Bladder Around To The Back

**Integument (Skin):** No Abnormality

Acne Rash Abnormal Masses or Bumps

**Neurologic (Nerves):** No Abnormality

Muscular Weakness Tingling/Numbness Difficulty Concentrating Memory Loss

**Musculoskeletal (Muscles/Bones):** No Abnormality

Back Pain Muscle Pain Joint Pain Neck Pain Curvature of the Spine

**Endocrine (Hormones):** No Abnormality

Increased Thirst (Polydipsia) Hot Flashes Night Sweats  
Increased Urination (Polyuria) Cold Intolerance Heat Intolerance  
Excessive Body Hair (Hirsutism) Hair Loss

**Psychiatric:** No Abnormality

Difficulty Sleeping Anxiety Depression Anorexia Bulimia Suicidal Thoughts

**Heme-Lymph:** No Abnormality

Easy Bruising Easy Bleeding Lymph Node Enlargement or Tenderness

**Allergic-Immunologic:** No Abnormality

Allergy Frequent Illnesses

The information on this Patient Health History Form is correct to the best of my knowledge.

Patient or Guardian Signature: \_\_\_\_\_

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

Physician Signature: \_\_\_\_\_

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

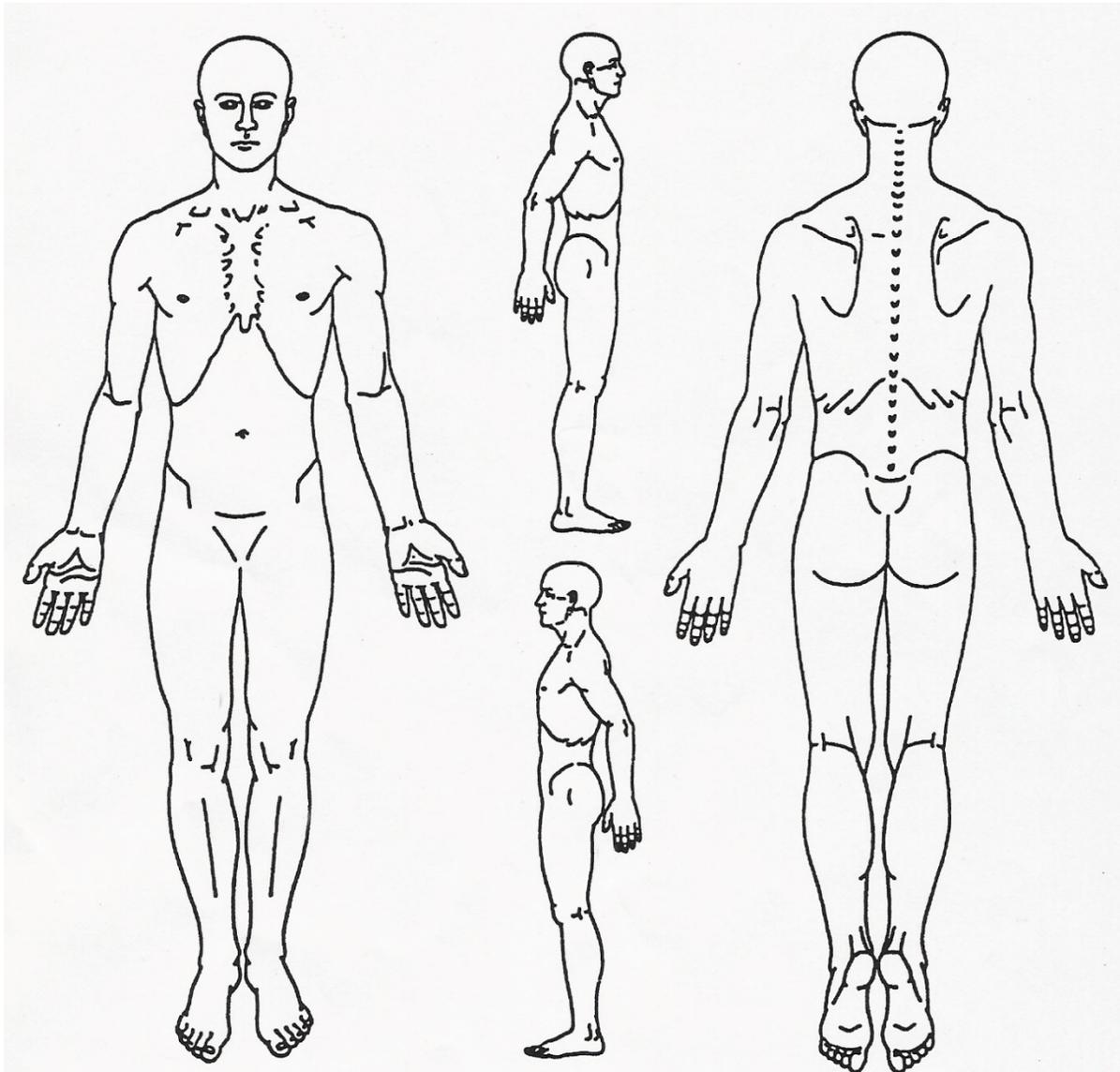
## PAIN DRAWING

Name: \_\_\_\_\_ Date Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain.

**(Include all affected areas – you may draw in the face as well.)**

<b>A = Ache</b>	<b>B = Burning</b>	<b>R = Radiating Pain</b>	<b>D = Dull Pain</b>
<b>N = Numbness</b>	<b>S = Stabbing</b>	<b>P = Pins &amp; Needles</b>	<b>O = Other</b>



**Please indicate how you would rate your pain** (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

- |                 |  |
|-----------------|--|
| a) Right Now    | (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable) |
| b) Average Pain | (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable) |
| c) At Best      | (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable) |
| d) At Worst     | (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable) |



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## INJURY QUESTIONNAIRE

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

Date and time of accident: \_\_\_\_\_  
 Auto Accident  Work Injury  Slip and Fall  Pedestrian hit by vehicle

Street / Intersection of the accident: \_\_\_\_\_

Direction you were heading?  North  South  East  West      Direction of other vehicle?  North  South  East  West

What type of vehicle you were driving? \_\_\_\_\_

What type of vehicle collided with yours? \_\_\_\_\_

Were you the?  Driver  Front passenger  Rear passenger      Were you wearing your seat belt?  Yes  No

Was the police notified?  Yes  No      Is there a police report?  Yes  No

Was anyone given a citation?  No  Me  Other Driver

On which side was your vehicle struck?  Front  Rear  Driver side  Passenger side      Airbags Deployed?  Yes  No

Did you feel pain right after the accident?  Yes  No

If yes, explain: \_\_\_\_\_

Were you rendered unconscious by the impact?  Yes  No      Were you treated at the scene of accident?  Yes  No

Were you driven to the ER by ambulance?  Yes  No

If yes, treatment given: \_\_\_\_\_

Did you seek other treatment after the accident?  Yes  No

If yes, where? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Are you currently being treated for this injury?  Yes  No

If yes, where? \_\_\_\_\_ Phone #: \_\_\_\_\_

When was your last date of treatment for this accident? \_\_\_\_\_

Please explain in full the details of this accident: \_\_\_\_\_

\_\_\_\_\_

What body part(s) was (were) injured? \_\_\_\_\_

\_\_\_\_\_

Any other injuries in the past? (auto, falls, work, etc...) \_\_\_\_\_

\_\_\_\_\_

Any similar complaints in the past before this recent accident? \_\_\_\_\_

\_\_\_\_\_

Are you currently working?  Yes  No      Have you lost time from work due to the accident?  Yes  No

If yes how long? \_\_\_\_\_





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**Authorization to Administer Treatment:**

I hereby give permission to the practitioners and staff at Total Vitality Medical Group, LLC to administer treatment, prescribe medication and/or testing procedures indicated by the practitioner he/she may deem necessary to diagnose and/or treat my condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Policy holder/Responsible Party

**Pregnancy Release for X-rays:**

I, \_\_\_\_\_, hereby state to the best of my knowledge that I am not pregnant and give my full consent to Total Vitality Medical Group LLC, their associates, and x-ray technicians to x-ray me.

My last menstruation cycle began on \_\_\_\_/\_\_\_\_/\_\_\_\_

**Minor Consent (if applicable):**

I hereby request and authorize Total Vitality Medical Group, LLC to render treatment to my minor child \_\_\_\_\_ . This authorization is extended to all affiliated doctors and staff members and is intended for the performance of diagnostic tests, chiropractic adjustments, radiographic examination (at the doctor’s discretion) as well as other treatment necessary for the minor child’s care. As of this date, \_\_\_\_\_, I have the legal right to select and authorize health care services for the minor child named above. (If applicable), under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize care to my child should be revoked or modified in any way, I will notify this office immediately.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian Print name

**RELEASE/ WAIVER/DISCLOSURE OF OWNERSHIP**

**RELEASE FORM**

I accept full responsibility for my use of any and all equipment owned by Total Vitality Medical Group, LLC, its shareholders, directors, employees, representatives or agents. I hold them harmless for any and all loss, claim, injury, damage or liability sustained or incurred by me resulting there from.

**WAIVER FORM**

I fully understand and agree that I am engaging in physical exercise and the use of exercise equipment owned by Total Vitality Medical Group, LLC which could cause injury. I am voluntarily participating in these activities and assume all risks that might result. I hereby agree to waive any claim or rights I might otherwise have to sue the facility, its employees or agents for injury on account of these activities. I have carefully read this waiver/release and fully understand it is a release of liability.

I understand that I have the right, at any time, to freely choose my provider and the facility in which they practice. Please contact our office for a list of provider/ownership responsibility.

\_\_\_\_\_  
Print Name Signature Date

\_\_\_\_\_  
Witness (print name) Witness Signature Date



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<b>FOR OFFICE USE ONLY</b>
Patient name:
Policy Owner's Name:
Insurance Carrier Name:
Policy/Claim #:
Date of Accident/Injury:

**Assignment of Benefits / Policy Rights**

**PATIENT:** I, the undersigned, understand and agree that **Total Vitality Medical Group, LLC** (including any other subsidiaries, all its corporative, elected, and appointed representatives, and officials, or its assigns), requires payment at the time of services are rendered. In consideration of the Provider agreeing to not require at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance which may be available to pay the Provider on my behalf to the said Provider. This agreement is for services and/or supplies rendered for treatment of personal injuries sustained in an automobile accident or incident on the above referenced date to me, the undersigned patient, who is covered by Personal Injury Protection (PIP) coverage or other insurance coverage under the above named Policy Owner's name, in accordance with Florida Statute 627.736.5. The undersigned is responsible for any applicable deductible or co-payment not covered by PIP or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above referenced insurance company, under the above referred policy or claim number.

The assignment is intended to transfer all of the patient's rights to collect benefits from the said insurance company, including, but not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This assignment further the right to collect payment for reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736(6). This assignment also includes any rights to recover attorney's fees and costs for any such action brought by the Provider as the patient's assignee. I agree that the said Provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my PIP/Bodily Injury claim or case. In the event of litigation or arbitration, I agree to cooperate with said Provider and in any manner reasonably required. I understand this cooperation may include giving sworn testimony at deposition, trial of the case, or any other proceeding that may be reasonably required and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this agreement by taking a position inconsistent with the said Provider's pursuit of payment.

The Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier and upon my execution. I hereby instruct the said insurance carrier in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, the amount of benefits claimed by the said Provider be placed in escrow and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the Provider immediately of any dispute as to payments so it may exercise its legal rights. I have read and understand the information herein, and it is true to the best of my knowledge and belief.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Print Patient/Responsible Party Name

\_\_\_\_\_  
Date

**PROVIDER:** The undersigned, on behalf of the above referenced Provider, hereby accepts assignment of the insurance rights and benefits for the services rendered to the above referenced patient. The undersigned also accepts payments to be paid directly to the above referenced Provider under the above referenced patient's PIP, or other insurance coverage with the above referenced insurance carrier and in accordance with Florida Statute 627.736 et Seq.

By: \_\_\_\_\_  
Authorized Agent/Representative

\_\_\_\_\_  
Date



**OFFICE LOCATIONS AND CONTACT INFORMATION:**  
 Clearwater – 24945 US Hwy 19 N, Clearwater, FL 33673; Phone: 727-726-1460; Fax: 727-724-9705  
 St. Petersburg – 1001 37<sup>th</sup> Street N Suite D, St. Pete, FL 33713; Phone: 727-914-9130; Fax: 727-914-9131 P  
 Brandon – 667 West Lumsden Rd. Brandon, FL 33511; Phone: 813-867-7323; Fax: 813-867-7326

**PHYSICIAN'S LIEN**

Name of Attorney(s)	Attorney(s) Address	Telephone
Patient's Name		Birthdate

I hereby authorize the above doctor to disclose to my attorney(s) a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident in which I was involved. The purpose of this disclosure is to permit my attorney to provide me with legal services.

- This authorization has no expiration date.
- I understand that I have the right to revoke this authorization by sending a written letter to the above-named doctor, except to the extent that the above-named doctor has already taken action in reliance upon this authorization.
- I understand that the information disclosed under this authorization may be re-disclosed by my attorney (s), and that the privacy be maintained under the Health Insurance Portability and Accountability Act.
- I understand that I may inspect or copy the information to be disclosed, except in those circumstances when inspection or copying of my information may be lawfully denied under federal law.
- I also understand that I may refuse to sign this authorization, and that the above-named doctor will not condition treatment on my providing authorization for this disclosure.

I hereby authorize and direct you, my attorney(s), to pay directly to said doctor such sums as may be due and owing him/her for professional services, supplies, items, reports, and proceedings rendered to me or on my behalf both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.

I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

- I fully understand that I am directly responsible to said doctor for all professional bills submitted by him/her for services rendered me that this agreement is made solely for said doctor's additional protection and in consideration of pending payment.
- I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian or Personal Representative	Date
Patient's Address	(____)_____ Telephone
City	State      Zip



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## Office/Financial Policy

Thank you for choosing **Total Vitality Medical Group (TVMG)** for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, personal in-state checks, VISA, MasterCard, Discover, American Express and Care Credit cards. Personal checks are not accepted.

### **OFFICE HOURS (By Appointment Only):**

Each location has different hours, please contact the office to verify the specific days/hours of operation.

- The office is closed from 12:00 pm to 2:00 pm

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. We do not have after-hours or weekend providers available.

### **INSURANCE:**

We participate in many insurance networks and will bill your insurance plan accordingly. If we do not participate with your insurance network, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan.

- **Proof of Insurance:** All patients must complete and/or update our Patient Information Form at the beginning of each year, and if when you change personal information. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

- **Co-payments and deductibles:** All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and non-covered services.

- **Claim submission:** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Florida insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. Referrals: If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require a 72 hour notice to facilitate a referral request and cannot issue retroactive referrals.

**OUT-OF-NETWORK CARE / SELF PAY:** Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, it is your responsibility to seek reimbursement through your insurance company. We will only send your claims for out-of-network care to your insurance if requested in advance. We will charge a self-pay rate.

Please contact the front office for current Self-Pay Pricing.

**ADMINISTRATIVE SERVICES, CHARGES AND PATIENT RESPONSIBILITIES:** Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- Missed appointments. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require **24-hour notice of cancellation to avoid a \$95 cancellation fee** for all appointments. It is your responsibility to remember your appointment.



**MULTI-DISCIPLINARY TREATMENT CENTERS**

24945 US Hwy 19 N, Clearwater, FL 33763 PH: 727-726-1460  
1001 37th St. N., Suite D, St. Petersburg, FL 33716 PH: 727-914-9130  
667 W. Lumsden Rd., Brandon, FL 33511 PH: 813-867-7323

- Prescription refills. New prescriptions will not be issued without first seeing your Physician. Prescriptions for acute care or chronic conditions are written with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. You will be charged **\$75** for any additional refills issued without seeing the Physician or to replace a lost prescription, as long as it’s a medication in which we are able to do so. All prescription requests are taken only during regular office hours and filled within 48 hours.
- Prescription Prior- authorizations. We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward the prior authorization form to our office. A **\$25** fee may be assessed for time to complete the prior authorization form. Any request for a forced change in your medication by your insurance company will require an office visit. The patient will need to ask their insurance plan what “alternative medications” are covered and provide a list to their Physician.
- Letters / Form completion. At the discretion of the Physician, letters and forms requiring medical review and Physician signature are subject to a **\$25** fee if completed without an appointment.
- Telephone Consultations: Telephone consultations calls for medical advice/treatment may be subject to a **\$150** fee that is billed directly to you.
- Requests for medical records. In accordance with Florida law, TVMG requires written requests for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current Florida law and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records.

**Personal Injury Cases**

- This office will bill for any auto accident or other liability or lawsuit related cases as a courtesy to you. It is your responsibility to provide us with the car insurance carrier name, claim number and any corresponding information prior to your visit in order to obtain proper authorization.

**Workers Compensation**

- If your injury is work related, it is your responsibility to provide us with the case number and carrier name prior to your visit in order to obtain proper authorization. We will be happy to bill your worker’s compensation insurance company as a courtesy to you.

**Assignment of Insurance Benefits (Health Insurance)**

Patients with insurance please read and sign below that you understand and agree with the following statement.  
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, or services provided by Total Vitality Medical Group LLC, to Total Vitality Medical Group, LLC. This assignment 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 I am financially responsible for all charges which remain unpaid by insurance. I hereby authorize said assignee to release information necessary to secure payment.  
I have read, understand, and agree to comply with the terms of your Office / Financial Policy for payment of professional fees.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (print name)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



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**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Printed Name of Patient (first, middle, last name)		Birthdate (mm/dd/yyyy)
Phone Number	E-mail	

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.  
I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information	
Phone Number	Fax Number

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information	
Phone Number	Fax Number

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. The following health information that relates to service beginning from \_\_\_\_\_ to \_\_\_\_\_, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)
- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

- |   |  |
|---|--|
| <input type="checkbox"/> Change of Doctor     | <input type="checkbox"/> Insurance Purposes  |
| <input type="checkbox"/> Individual Request   | <input type="checkbox"/> Continued Treatment |
| <input type="checkbox"/> Specialist Referral  | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Other: _____        |

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority:
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