

Medical History

Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____ **Left** or **Right** Handed Occupation: _____
(circle one)

Reason for Visit: _____

Approximate date of onset: _____ If injury, how did it happen: _____

Known Health Problems: (Please list) _____

All Surgery or Operations: _____

Please list all **prescription and non-prescription medications** you are taking. If none please write “None”

Medication: _____ Dose: _____ Frequency: _____ Medication: _____ Dose: _____ Frequency: _____

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Medication Allergies: (if none write “None”) _____ **Women: Any chance of pregnancy?** Yes No

Do you smoke? (How much per day) _____ **Alcohol Consumption:** Daily _____ Weekly _____ Monthly _____ Size _____

Substances: Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each substance that you’ve circled, indicate if you used it **Occasionally** “O” **Frequently** “F” **Continuously** “C”

Alcohol _____ Barbiturates _____ Cocaine _____ Heroin _____ Amphetamines _____ Marijuana _____ Painkillers _____

Other: _____

Are you presently using any of the drugs or substances below? (Circle all that apply)

Alcohol Barbiturates Cocaine Heroin Amphetamines Marijuana Painkillers Other: _____

Have you ever been treated for or had a professional recommend treatment for alcohol or substance abuse? Yes No

In your opinion, do you have or have you ever had a problem with alcohol or other drugs? Yes No

Please **describe the type of work** that you do: _____

If you feel **any other activities** may relate to your problem, please describe: _____

Conditions: (Check all conditions you have or have had in the past)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid or Goiter | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding or Clotting | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Disorder | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Ulcer/Reflux | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Aids or HIV | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Liver Disease or Hepatitis | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Shingles | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cancer: TYPE: _____ | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Breast Lump | |

Review of Systems: (Check all conditions you have or have had in the past)

GENERAL

- Unexplained Changes in Weight Fever or Chill Sweats Change in Voice Tiredness

HEAD

- Headache Head Injury Visual Problems Hearing Problems Vertigo (Dizziness) Ear Pain
 Tinnitus (Ringing in Ears) Sinus Problems Dental Problems Any Mental Complaints

NEUROLOGICAL

- Head Pain Head Trauma/Injuries Seizures/Epilepsy Tingling (Pins & Needles) Loss of Consciousness Tremors/Shaking Pinched Nerve Difficulty Walking Weakness/Paralysis
 Numbness/Loss of Sensation Memory Problems Disorientation Difficulty Speaking
 Difficulty Swallowing Double Vision Loss of Vision Difficulty Writing Difficulty Reading

MUSCULAR / SKELETAL

- Muscle Aching Weakness Joint Swelling Joint Pain or Stiffness Neck Pain Arthritis
 Low Back Pain Injuries: (Specify) _____

SLEEP

- Insomnia Snoring (Excessive) Daytime Drowsiness (Excessive)

CARDIAC/VASCULAR/HEART

- Chest Pain Palpitations Heart Murmur Fainting Swollen Feet/Legs Blood Vessel Problems

LUNGS

- Coughing/Wheezing Shortness of Breath Coughing Up Blood

GASTRO-INTESTINAL

- Change in Appetite Digestion Problems Gas Nausea Vomiting Constipation
 Diarrhea Abdominal Pain

GENITAL/URINARY

- Difficulty Urinating Incontinence (Loss of Urine) Kidney Stones Urinary Infections Impotence
 Other Sexual Problems Women: Irregular Periods

SKIN/HAIR

- Change in Hair Skin or Scalp Lesions Rash Dryness Itching

ENDOCRINE/HEMATOLOGICAL ALLERGY IMMUNE

- Sensitivity to Temperature Unusual Thirst or Hunger Excessive Urination Bloating
 Swollen Glands Pale Color Multiple Allergies Frequent Colds/Infections

Family Medical History:

Known Health Problems

Age (or age at death if deceased)

Father: _____

Mother: _____

Sister: _____

Brother: _____

Child: _____

Patient Initials: _____

Reviewed by physician: _____

Date: _____

Date: _____

WELCOME TO ROBERT J. FRIEDMAN, M.D., P.A.**AUTHORIZATION AND FINANCIAL AGREEMENT****Insurance Coverage**

HPC has made prior arrangements with several insurance companies. We will bill those plans with which we have an agreement and will only require you to pay the applicable co-payment or deductible at the time of service. If you have insurance coverage with a plan that we are not participating with, HPC will file insurance claims for you to your insurance for medical services. These patients are required to pay HPC in advance for the estimated cost of services and procedures.

Your insurance policy is a contract between YOU and your insurance company. All health plans are different and cover different services. In the event your insurance company determines a service to be "not covered or not medically necessary" or over the usual and customary charge, you will be responsible for the complete charge.

If you are a Medicare recipient with Supplemental or Secondary insurance that covers the Medicare 20% or Deductible, WE WILL FILE AS A COURTESY. If your Supplemental/Secondary insurance does not reimburse HPC within sixty (60) days, it will become your responsibility. If you have no supplement, or your supplement is with a company that we know does not "crossover" automatically from Medicare, you will be responsible for the 20% at the time of service.

Laboratory Testing

Patients requiring laboratory testing are sent to an outside lab facility that your insurance requires. These lab tests are done at and by its facility and HPC is not responsible for any billing related to those services. If you have any questions about lab or diagnostic test billing, it is your responsibility to contact these facilities direct, not us.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. This parent or guardian will be listed as the guarantor in our system.

Our Office Charges for the Following

Telephone calls from the doctor at the patient's request will fall under our TeleHealth Agreement. If you feel you may need these services in the future, please notify our Staff and an Agreement will be made available to you for your review and signature. TeleHealth consults are typically non-covered by insurance and would be your responsibility. Any and ALL forms to be filled out at your request will incur a fee of \$10 and up; Patient's requesting a prescription refill by phone in lieu of office visit will cost \$25.00. Returned check fees are \$50.00.

Before and After Hour Appointments

Patient appointments before 8:30am and after 5:00pm will incur a charge of \$50 for New Patients and \$30 for Follow-Up appointments. This charge is not covered by insurances and is the patient's responsibility. You will be required to pay this fee in addition to any applicable copays or deductibles.

Cancellation Policy

With the understanding of the significant expenditures for equipment, treatment supplies, staffing, scheduling, and other costs, once appointments are scheduled the patient is responsible for keeping that appointment. Patients who cancel or miss an appointment without prior 48 hour notice will be charged a fee. Extenuating circumstances will be considered on an individual basis. The charges are as follows: Office Visits: New Patients: \$ 150.00; Follow-up appointments \$ 60.00; Procedures \$130.00 If your appointment is canceled or rescheduled by HPC, you will not be charged for the canceled appointment. If you arrive at the office more than 30 minutes late, this will be considered a no-show in most instances. **Exceptions may be made for acute illness or other emergency only at the sole discretion of HPC.** This charge is not covered by insurances and is the patient's responsibility.

I authorize the patient's insurance company, attorney, or Medicare to pay direct to Robert J. Friedman, MD any medical expenses payable under the terms of the contract. I have read and understand the financial policy of Robert J. Friedman, M.D., P.A. and agree to be bound by its terms. Photocopies of this form will be valid. I also agree that any balance not covered will be paid by me. I understand that should this account be referred to an agency or attorney for collection that I will be responsible for all collection and court costs and attorney's fees. Delinquent accounts beyond 90 days are subject to the maximum interest allowed by law. I further authorize the physician in charge of the care of the patient to administer such medical care as may be deemed advisable in the diagnosis (and treatment) of this patient. I certify that the information I have reported with regard to my insurance coverage is true and accurate. If my insurance company has not paid or denied my claim in 30 days, I give Robert J. Friedman M.D. my consent to seek assistance and lodge complaints to the Insurance Commissioner's office on my behalf. I agree to the policies of this office and wish to be seen.

Print Name: _____ **Signature:** _____ **Date:** _____



Robert J. Friedman, MD

Board Certified in Neurology | Board Certified in Pain Management
Board Certified in Neuromuscular Medicine | Certified Independent Medical Examiner

OFFICE TELEPHONE: 561-842-PAIN (7246)

FACSIMILE: 561-408-0950

www.PalmBeachPain.com

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Please accept this document as a formal request for patient information.

****PLEASE FAX RECORDS TO: (561)408-0950****

Please Disclose the Following to the Medical Provider Above:

Office Notes, Diagnostic Reports, Labs, Imaging, Surgical Notes, Hospitalizations and ER Notes

Sensitive Health Information:

By checking any of the boxes below, I do not imply any of these conditions are present but if so, I agree for their release. I specifically authorize the use and/or disclosure of the type of Protected Health Information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability
- Psychotherapy Notes
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s)
- Information about Alcohol/Drug Abuse Treatment
- Information about Abuse/Neglect of an Adult with a Disability
- Information about Sexual Assault
- Information about Child Abuse/Neglect
- Information about Genetic Testing

Expiration Date of Authorization This Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation.

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Patient Signature

Date

If someone else is signing this Authorization on behalf of the Patient, please provide the following information:

Legal Representative *

Date

Relationship to the Patient

Note: * Please provide written documentation to support your status as a legal representative and/or guardian.