HEADACHE & PAIN
CENTER OF PALM BEACH

Medical History

Name: _____ Age: _____ Date: _____

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

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:**_____

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

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

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)

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

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: _____

Pain Drawing

Name: _____ **Date**: _____

Date of Birth: _____ **Examiner**: _____

Tell Us Where You Hurt

Please read carefully:
Mark the areas on your body where you feel you pain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > >

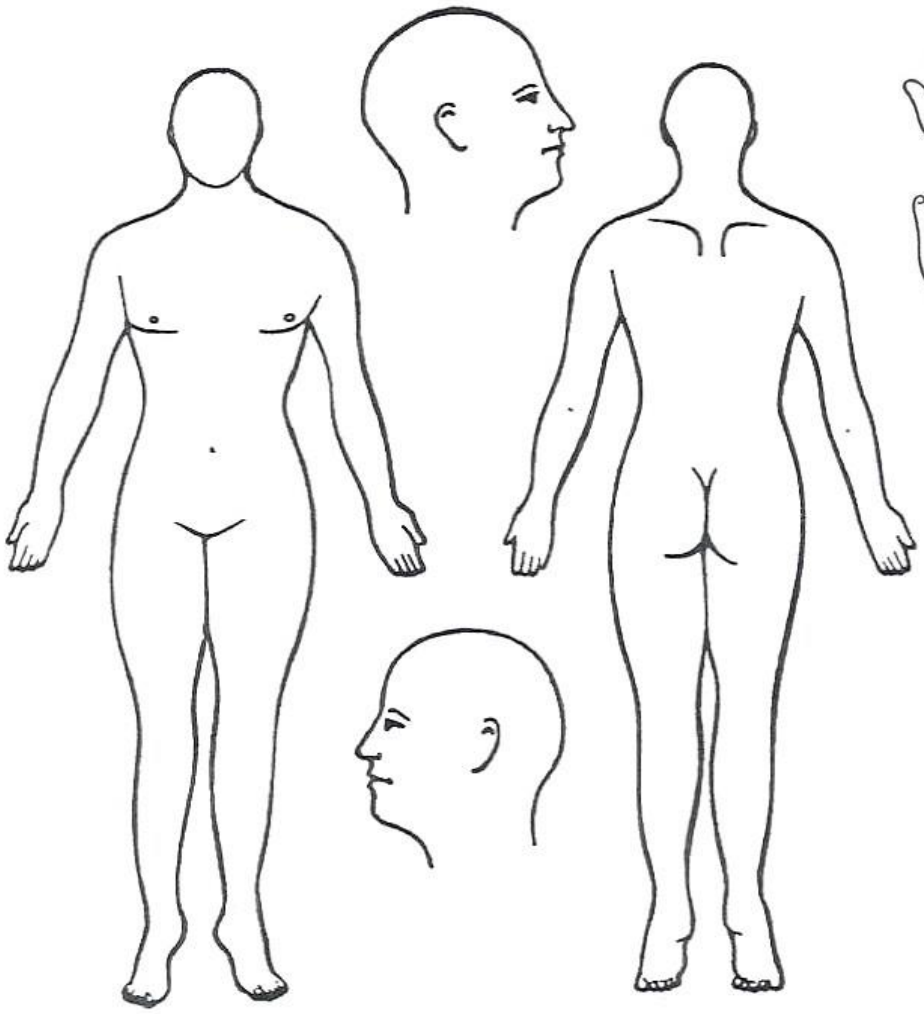
Numbness = = = =

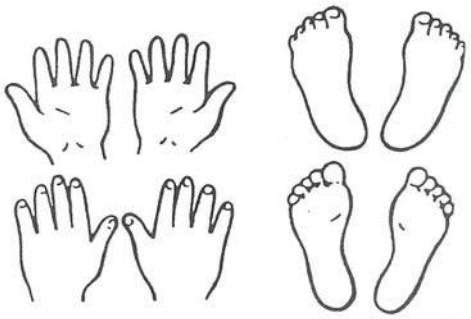
Pins and Needles o o o o
o o o o

Burning x x x x

Stabbing / / / /

Throbbing ~ ~ ~ ~





Severity of Pain

List the region of pain. Circle the severity number.
1=least pain, 10=greatest pain

ex: NECK
0 1 2 3 4 5 6 7 8 9 10

1. _____
0 1 2 3 4 5 6 7 8 9 10

2. _____
0 1 2 3 4 5 6 7 8 9 10

3. _____
0 1 2 3 4 5 6 7 8 9 10

4. _____
0 1 2 3 4 5 6 7 8 9 10

5. _____
0 1 2 3 4 5 6 7 8 9 10

HEADACHE & PAIN
CENTER OF PALM BEACH

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.

Advanced Practitioners

I understand that, by being referred to Dr. Robert Friedman, I may choose to see the Advanced Practitioner instead.

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.

Cancelation 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**: _____

HEADACHE & PAIN
CENTER OF PALM BEACH

Robert J. Friedman, MD PA
Board Certified in Neurology | Board Certified in Pain Management
Board Certified in Neuromuscular Medicine | Certified Independent Medical Examiner
TELEPHONE: 561-842-PAIN (7246) FACSIMILE: 561-408-0950
www.NewPainTreatments.com
5600 PGA Blvd | Suite 200 | Palm Beach Gardens, FL 33418

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
HOSPITAL _____

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.

POWER OF ATTORNEY and MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGMENT OF BENEFITS/AUTHORIZATION TO PAY

Know by all these present that: The undersigned has made, constituted and appointed, and by these present does hereby make, constitute and appoint Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm Beach and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or the undersigned and the said Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm which checks, draft or money orders are made payable for services which have been made by Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm which checks, draft or money orders are made payable for the maker of the check, draft or money order.

Furthermore, the undersigned allows Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplied pertaining to me to release true copies of same to Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm all actions taken by the said attorney in accordance to this special power and which the said attorney shall do or cause to be done by this virtue of these present.

ASSIGNMENT OF BENEFITS

I,_____Hereby authorize_____

(Name of insured) (Name of Insurance Carrier)

Payable directly to: Robert J. Friedman, MD PA
Payable and mailed directly to: 5600 PGA Blvd Suite 200
Palm Beach Gardens, FL 33418

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Status for any service and/or charges provided by Robert J. Friedman, MD PA d/b/a Headache & Pain Center of Palm.

IN WITNESS WHEREOF THE UNDERSIGNED have hereunto set their hands, this_____day of_____,20___.

PATIENT'S SIGNATURE PATIENTS NAME (PLEASE PRINT)

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 or treatment 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.

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.

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

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, 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. The treatment or services rendered were explained 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.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature of Provider	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.