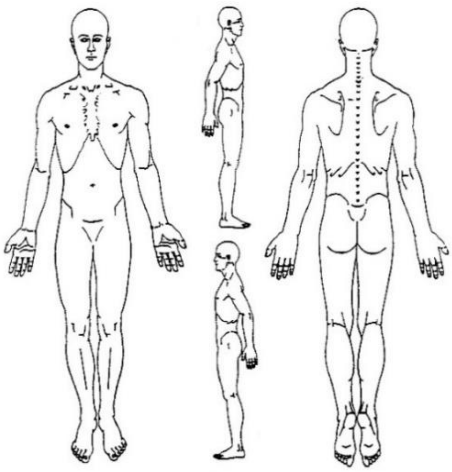
JAFFE SPORTS MEDICINE
PHYSICAL THERAPY | PAIN MANAGEMENT | ORTHOPEDIC SURGERY

Patient Name: _____Date: _____
Referring Physician / Source: _____ Primary Care Physician: _____

Assess Your Pain:
Where is your pain and where does it go? _____
When did it start? _____

Intensity - on a scale of 1 – 10, with 1 being the lowest and 10 being the highest, please rate your pain below.
0 1 2 3 4 5 6 7 8 9 10



On the diagram at the right, please indicate where your pain is located.

Please describe your pain (check all that apply):

☐SHARP ☐DULL ☐BURNING ☐ACHING ☐THROBBING ☐OTHER_____

☐CONSTANT ☐INTERMITTENT

I have: ☐pins and needle sensation ☐loss of sensation ☐muscle weakness

Have you experienced bowel or bladder changes? ☐Yes ☐No

Does the pain affect your sleep? ☐Yes ☐No

List the activities that increase your pain: _____

List the activities that decrease your pain: _____

Medical History:
Please list ***all current medications*** and ***dosage*** that you are currently taking:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Please list ***any allergies to medication*** or ***other allergies*** that you have:

_____ _____ _____ _____ _____

Pharmacy: _____ Phone Number: _____

Please list ***any medical or health problems*** that you ***have now*** or ***had in the past***:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Please list ***any surgeries*** that you have had, giving dates and procedure:

_____ _____ _____ _____ _____

Family / Social History:
Please check ***any medical problems*** that run in your family:

☐HEART DISEASE ☐LUNG DISEASE ☐LIVER DISEASE ☐KIDNEY DISEASE ☐GI DISORDERS ☐DIABETES ☐STROKE

Please describe your **present family situation**: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOW/ER

Do you drink **alcohol**? ☐Yes ☐No If yes, how often? _____

Do you **smoke**? ☐Yes ☐No If yes, how much/long? _____

Do you use **illegal substances**? ☐Yes ☐No If yes, what? _____

Are you **presently employed**? ☐ Yes ☐ No Occupation: _____

Review of Systems

1. **Constitutional Symptoms**
   a. Fever □Yes □ No
   b. Chills □Yes □ No
   c. Headache □Yes □ No
   d. Other_____ □Yes □ No
2. **Eyes**
   a. Blurred Vision □Yes □ No
   b. Double Vision □Yes □ No
   c. Pain □Yes □ No
   d. Other_____ □Yes □ No
3. **Allergic/Immunologic**
   a. Hay Fever □Yes □ No
   b. Drug Allergies □Yes □ No
   c. Other_____ □Yes □ No
4. **Neurological**
   a. Tremors □Yes □ No
   b. Dizzy Spells □Yes □ No
   c. Numbness/Tingling □Yes □ No
   d. Other_____ □Yes □ No
5. **Endocrine**
   a. Excessive Thirst □Yes □ No
   b. Too hot/cold □Yes □ No
   c. Tired/Sluggish □Yes □ No
   d. Other_____ □Yes □ No
6. **Gastrointestinal**
   a. Abdominal pain □Yes □ No
   b. Nausea/Vomiting □Yes □ No
   c. GERD/heartburn □Yes □ No
   d. Other_____ □Yes □ No
7. **Integumentary**
   a. Skin rash □Yes □ No
   b. Boils □Yes □ No
   c. Persistent Itch □Yes □ No
   d. Other_____ □Yes □ No
8. **Musculoskeletal**
   a. Joint Pain □Yes □ No
   b. Neck Pain □Yes □ No
   c. Back Pain □Yes □ No
   d. Other_____ □Yes □ No
9. **Ear/Nose/Throat/Mouth**
   a. Ear infection □Yes □ No
   b. Sore throat □Yes □ No
   c. Sinus problems □Yes □ No
   d. Other_____ □Yes □ No
10. **Genitourinary**
   a. Urine retention □Yes □ No
   b. Painful urination □Yes □ No
   c. Urinary frequency □Yes □ No
   d. Other_____ □Yes □ No
11. **Respiratory**
   a. Wheezing □Yes □ No
   b. Frequent Cough □Yes □ No
   c. Shortness of breath □Yes □ No
   d. Other_____ □Yes □ No
12. **Hematologic/Lymphatic**
   a. Swollen glands □Yes □ No
   b. Blood clotting prob. □Yes □ No
   c. Tired/Sluggish □Yes □ No
   d. Other_____ □Yes □ No
13. **Psychological**
   a. Depression □Yes □ No
   b. Suicidal thoughts □Yes □ No
   c. Dissatisfied with life □Yes □ No
   d. Other_____ □Yes □ No

Note to patient: You are advised to follow up with your primary care physician for any general medical issues you have answered yes to.

Patient Name: _____
Patient/Guardian Signature: _____ Date: _____
Physician Signature: _____ Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT & AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to provide you with our notice of Privacy Practices which explain our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask you authorize when, and to whom, protected health information can be released.

MAY WE PHONE, EMAIL, OR SEND A TEXT TO YOU TO CONFIRM YOUR APPOINTMENT? YES NO
MAY WE LEAVE A DETAILED MESSAGE ON YOUR HOME PHONE OR CELL PHONE? YES NO
DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? YES NO

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS, & RELATIONS TO YOU:

NAME: _____PHONE: _____RELATION: _____

NAME: _____PHONE: _____RELATION: _____

NAME: _____PHONE: _____RELATION: _____

By signing this form, I acknowledge that I have received a copy of Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation Notice of Privacy Practices and have been given the opportunity to ask questions. A copy of this content will be included in my chart for future reference.

PATIENT NAME: _____DATE: _____

PATIENT SIGNATURE: _____DATE: _____

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MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

Reason for Request: _____

Records Requested: **_____ All Records**

_____ Operative Report (s)

_____ Specific date (s) of service

_____ MRI / X-ray / CT Scan

Release records to:

_____ REGIONAL REHAB ASSOCIATES PA, dba JAFFE SPORTS MEDICINE- PLEASE MAIL TO THE ABOVE ADDRESS OR FAX TO 855-959-1692

_____ OTHER (PLEASE PROVIDE NAME, ADDRESS, PHONE, AND FAX)

_____

_____

_____

_____ PATIENT ( ) MAIL ( ) PICK UP

PATIENT NAME: _____DATE: _____

PATIENT SIGNATURE: _____DATE: _____

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FINANCIAL POLICY

Medicare Part B
Regional Rehab Associates, PA dba Jaffe Sports Medicine is a Medicare part B provider. We will accept assignment on all Medicare Part B claims. By accepting assignment, we agree to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplemental insurance the 20% balance. If there is any remaining after Medicare and the supplemental insurance payment, it is the patient's responsibility.

Private Health Insurance and Managed Care Networks
As a courtesy to you, we will file claims with your insurance company. Please understand, however, that your insurance reflects a contract between you and the insurance company, not Regional Rehab Associates, PA dba Jaffe Sports Medicine. You, as the patient are ultimately responsible for your bill. Patients without health insurance will be expected to pay at the time of service or to make payment arrangements with the billing office. We may also collect at the time of service, any fee that will be paid directly to you from the insurance company, as well as any co-pays. co-insurance, and/or deductible amounts.

Self-pay patients or patients without health insurance – You will be expected to pay in full at the time of service or to make payment arrangements with the billing office.

Worker's Compensation – patients will supply worker's compensation contact information with authorization prior to services being rendered.

Motor Vehicle/Third Party Liability – Patients are financially responsible for medical services related to motor vehicle accidents. Patients shall supply auto insurance, third party and/or attorney information as requested by Regional Rehab Associates, PA dba Jaffe Sports Medicine.

Non covered services
Not all services are covered by all insurance health plans. **Services not covered or considered payable by the Insurance Company becomes the patient's responsibility and must be paid at the time of visit.**

Coverage Changes - If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits.

Non-Payment – If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If your account is past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Cancellation and Missed Appointment Policy
Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of medical care.

There is a $50 cancellation fee for missed procedures, consultations, and physical therapy. The fee will be waived if any canceled, missed, or no-show appointments are rescheduled and attended within the same business week

Cancellation of an Appointment - In order to be respectful of the medical needs of other patients, call Jaffe Sports Medicine promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Failure to provide 24-hour notice of cancellation or reschedule and attended within the week will result in a ***$50 cancellation fee.*** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel appointments, please call the office. If you do not reach the receptionist, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please leave your phone number.

No-Show - Failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". A missed appointment results in a ***$50 missed appointment fee***

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of the accounts in the event the following authorization is insufficient to liquidate the account.

I request the payment of authorized Medicare benefits be made on behalf of Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation, for any services rendered.

I hereby assign and transfer any insurance benefit due to me for the professional services that I have received, to Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation.

I authorize the release of any medical information necessary to process insurance claims.

PATIENT NAME: _____DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

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CONSENT FOR THE PURPOSE OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

General Consent:

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that my Medical History is complete and accurate to the best of my knowledge and ability. I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risks.

Protected Health Information:

The Notice of Privacy Practice for Regional Rehab Associates PA dba Jaffe Sports Medicine has been provided to me. I understand I have the right to review Notice of Privacy for Regional Rehab Associates PA dba Jaffe Sports Medicine prior to signing this document. The Notice of Privacy Practices for Regional Rehab Associates PA dba Jaffe Sports Medicine describes the types of uses and disclosures of my protected health that will occur in my treatment, payment of my bills, or the performance of Regional Rehab Associates PA dba Jaffe Sports Medicine operations. A summary of the Notice of Privacy Practices for Regional Rehab Associates PA dba Jaffe Sports Medicine is also posted in the waiting room. This notice of Privacy Practices for Regional Rehab Associates PA dba Jaffe Sports Medicine also describes my rights and the duties of Regional Rehab Associates PA dba Jaffe Sports Medicine with respect to my protected health information. Regional Rehab Associates PA dba Jaffe Sports Medicine reserves the right to change the Privacy Practices that are described in the Notice of Privacy for Regional Rehab Associates PA dba Jaffe Sports Medicine. I may obtain a revised Noticed of Privacy Practices for Regional Rehab Associates PA dba Jaffe Sports Medicine by contacting the office at 1865 Veterans Park Drive, Suite 101, Naples FL 34109 by calling (239) 254-7778.

Release of Information:

I specifically authorize the uses and disclosures of my health information as described in the Noticed of Privacy Practices Provided to me. I authorize Regional Rehab Associates PA dba Jaffe Sports Medicine and or staff, obtain my medication history and other relevant health care information, verbally, written or electrically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organization responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

Regional Rehab Associates, PA dba Jaffe Sports Medicine and Rehabilitation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

By signing below, I am agreeing to the consents and releases described on this form. I have read this consent and have been able to ask questions.

PRINTED PATIENT NAME: _____DATE: _____

PATIENT SIGNATURE: _____

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Patient Media Consent Form

I, _____, grant permission to Jaffe Sports Medicine hereinafter known as the "Media" to use my image (photographs, video & testimonials) for use in Media publications including:

(Check All That Apply)
❏ Videos ❏ Email Blasts ❏ Recruiting Brochures ❏ Newsletters ❏ Magazines
❏ General Publications ❏ Website and/or Affiliates ❏ Social Media

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please initial the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

PRINTED PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

ADDRESS: _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____
(If under 20 years of age)