Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 P: 727-216-3492 F: 727-216-3495

We're delighted you're here! Who can we thank?

Dr referral: _____ **Friend/Family name:** _____

Our Website: ____ **Facebook:** ___ **Yelp:** ___ **Twitter:** ___ **Pinterest:** ___ **GOOGLE:** ____ **Other:** _____

Patient #_____ **(Office Use Only)** **If expecting, Due Date:** _____

Date of Appointment: _____ **Time:** _____ **Appt w/**_____

Mr. Mrs. Miss Ms. Dr. **Preferred/Nickname:** _____ Birth Date: _____

(**Please PRINT**) Please Circle: Female / Male Marital Status: S M W D P

Name: _____

Address: _____ City, State, **Zip**: _____

Occupation: _____ Employer: _____

SS#: _____ E-Mail: _____

SS# optional for identification; ***ONLY required for VA*** *Email address required for email appt reminder*

Home Phone Number: (_____)_____ Cell Phone: (_____)_____

Cell Phone number required for text appt reminder

Work Phone Number: (_____)_____ ****Best Way to Reach You**: Home Cell Work

Emergency Contact: _____

(Name, relationship & phone number with area code)

Please Circle Your Appointment Reminder Preference: Text / Email / None

Primary Physician's Name: _____ PCP's Phone: _____

Referring Doctor's Name: _____ Dr.'s Phone #: _____

Doctor's Address: _____ Dr.'s FAX #: _____

MY PAYMENT METHOD: (Please circle ONE)

Physical Therapy – **CASH VA TRADITIONAL MEDICARE* ****

Cash Payment will be made when treatment is rendered. Detailed receipts are available.
Cash; Check; FSA/HSA cards *or* Credit/Debit cards (Visa; Master Card; American Express or Discover)

***Medicare Home Healthcare Verification**: **I hereby verify that I have NO open home healthcare order. I agree that failure to disclose an Open Home Healthcare Order will result in Medicare denying my claim; I assume all financial responsibility and will pay for the treatment(s) I receive(d). _____ (Initial)**

****** **I confirm I understand Evolution Medical Associates is "In Network" with Traditional Medicare ONLY. _____ (Initial)**

Privacy Statement: Your information will be shared only with your doctors and other healthcare practitioners directly involved in your care. If using insurance, information will be sent to insurers as requested. Full HIPAA forms available upon request. Rev. 8.1.19

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(Please PRINT) Patient #_____ (Office Use Only) **PATIENT HISTORY FORM** Today's Date: _____

Name: _____ Birth Date: _____ _____

Do You Smoke? Y N How Much? How Often? _____ _____

Drink Alcohol? Y N How Much? How Often? _____ _____

HEAD
___ Brain Injury
___ Seizures
___ Aneurysm
___ Encephalitis

EYES
___ Glaucoma
___ Cataracts

EARS
___ Miniere's
(Type: _____)
___ Hearing Loss
___ Tinnitus

THROAT
___ Sleep Apnea
___ Snoring
___ Thyroid Disease

LUNGS
___ Emphysema
___ Pleurisy
___ Pneumonia
___ Asthma

HEART
___ Atrial Fibrillation
___ Blood Clots
___ High Blood Pressure
___ Irregular Heart Rate
___ Pacemaker
___ _____

JOINTS
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Gout
___ Osteoporosis
___ Osteogenesis Imperfecta
___ Broken Bones:
(_____)

NEUROLOGICAL
___ Multiple Sclerosis
___ Polio
___ Parkinson's
___ Stroke
___ Meningitis
___ Migraines

GYN
___ # of Pregnancies
___ Cramps
___ Endometriosis
___ Fibroids

ENDOCRINE
___ Diabetes Mellitus Type 1
___ Diabetes Mellitus Type 2
___ Hypoglycemia

DISEASES
___ HIV / AIDS
___ Hepatitis
___ TB

MISCELLANEOUS
___ Cancer
(Type: _____)
___ Anxiety
___ Depression
___ Panic Attacks
___ CFS
___ Fibromyalgia
___ GERD (Acid Reflux)

OTHER: _____

SURGERIES: _____

Allergies: _____

Current Prescription Medications: _____

_____

Current Over the Counter Medications: _____

Vitamins / Supplements / Herbs: _____

_____

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People we may talk to about your status (circle): Spouse/Partner Children Parents Siblings Physicians (other than referring) Other Healthcare practitioners Other (specify):_____

Home Situation: Do you live in a (circle): House Apartment Condo Mobile Home
Do you live alone? Yes No If no, who do you live with?_____
Number of steps to enter home: _____ Number of steps inside home: _____

Patient #_____ **PHYSICAL THERAPY PATIENT HISTORY** Today's Date: _____

(Office Use Only)

Name: _____ **Birth Date**: _____

Height: _____ **Weight**: _____

Reason for today's visit: _____

Are you pregnant? _____ How many weeks? _____ Due Date? _____

Have you seen a doctor for this issue? _____

What Tests/Surgeries have you had done for this issue? _____

Other current Therapies: _____

When did this issue begin? _____

What caused this issue? _____

Rate Your Pain and/or Swelling on a Scale of 0 – 10 (0 = NO Pain; 10 = Go to the Emergency Room) :

At it's **Best** _____ At it's **Worst** _____ **Today** _____

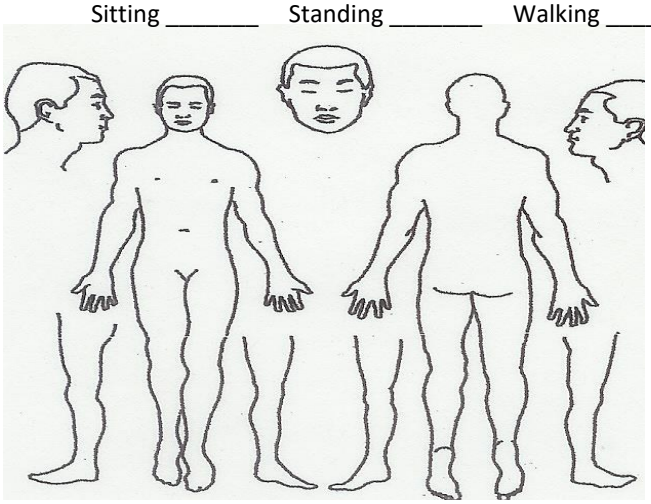
Is Your Pain and/or Swelling Constant? _____ Or, Does it Come and Go? _____

Is it Worse in the Morning? _____ Midday? _____ Or, in the Evening? _____

How Often do You have this Pain and/or Swelling? _____

Activities or Movements that are Painful to Perform: Reaching_____ Lifting_____

Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down _____



Please mark on this drawing

Areas where you have

Pain and/or Swelling.

Limitations you Currently have due to your Pain and/or Swelling. (Sleep, Self-Care, Socializing, etc.): _____

_____

_____

Previous activity level, including exercise, recreation, job, etc.: _____

_____

_____

Do you have any difficulty getting around your home? If so, Explain: _____

_____

What is your Goal for this therapy?: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Evolution Medical Associate (Phone: 727/216-3492)
ADDRESS	ADDRESS 604 Druid Road E (Fax: 727/216-3495)
CITY/STATE	CITY/STATE Clearwater, FL 33756

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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AUTHORIZATION for RELEASE OF INFORMATION

for USE, COPYING, DISCLOSURE and INSPECTING of PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE of BIRTH: _____ SOCIAL SECURITY NUMBER: _____

1. I hereby authorize _____ (hereinafter "Medical Provider") to use, copy, disclose or allow inspection of protected health information about me as described below. A photocopy of this authorization is as valid as an original.

2. The information to be disclosed is for all dates of service requested and includes:
   _____ Complete medical records, including but not limited to, office notes, progress notes, procedure notes, operative reports, intake questionnaire and patient history form
   _____ Physical therapy records _____ Massage therapy records _____ Billing records
   _____ Benefits information, incl health insurance, workers' compensation, Medicare, Medicaid, and disability coverage
   _____ Other: _____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse: or mental or behavioral health or psychiatric care.
4. I understand that copies of the records indicated above may be sent to my attorneys, _____ as said records are needed to assist in their representation on my behalf.
5. I understand that the information used or disclosed may be subject to re-disclosure by the Law Office of _____ and would then no longer be protected by federal or state privacy regulations.
6. I understand that I may revoke this authorization by notifying the Medical Provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. Unless otherwise revoked, I understand that this authorization expires on _____.
8. I understand that the Medical Provider may not condition treatment on my completion of this authorization form.
9. I understand that the Medical Provider may charge a fee for the costs of copying, mailing or supplying the requested information.

I, _____, hereby give consent for agents of Evolution Medical Associates LLC to release specified information to and discuss issues regarding me with the people and entities listed below:

_____ _____ _____

Printed Name **Printed Name** **Printed Name**

_____ _____

Signature of Patient or Parent, Guardian or Personal Representative **Date**