ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION
636 WEST BROADWAY, NORTH LITTLE ROCK, AR 72114

(501) 374-1153
FAX: (501) 374-6213

NEW PATIENT INFORMATION

Please Print all Answers

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

☐ Married ☐ Single ☐ Sep ☐Divorced ☐ Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Relative or Friend Not Living with You _____ Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

Patient Name: _____ ID#: _____

ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION
636 WEST BROADWAY, NORTH LITTLE ROCK, AR 72114
(501) 374-1153
FAX: (501) 374-6213

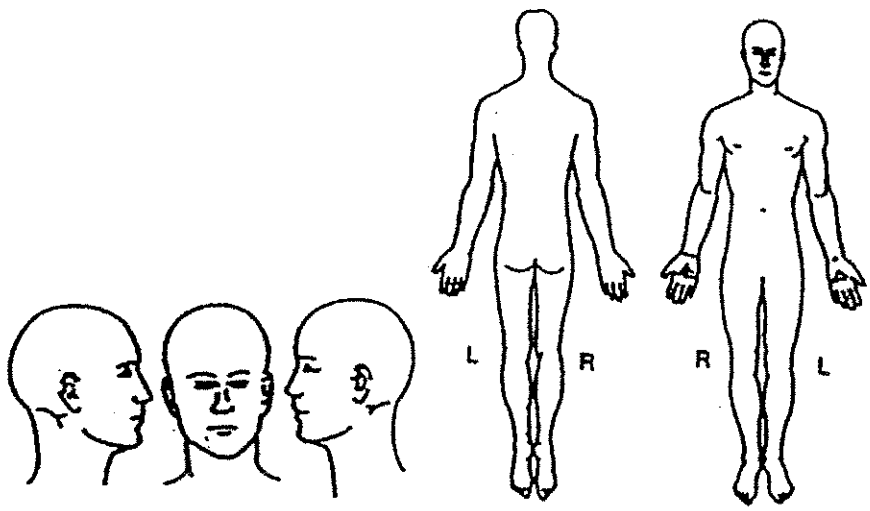
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Pain	: : : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X

Describe your pain (check all that apply):

- ☐ Constant
- ☐ Intermittent
- ☐ Recurring
- ☐ Stabbing
- ☐ Dull Ache
- ☐ Sharp
- ☐ Deep Ache
- ☐ Throbbing
- ☐ Tingling
- ☐ While Resting
- ☐ Daily
- ☐ During Exercise
- ☐ Nightly
- ☐ _____



Onset of Pain:

- ☐ Sudden
- ☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

AUTO ACCIDENT Date _____ Time ____ [am] [pm] Location _____

Were You	☐ Driver	☐ Passenger
	☐ Unconscious	☐ Treated in E.R.
	☐ Wearing a Seat Belt	☐ YES ☐ NO
	☐ Transported by Ambulance	☐ YES ☐ NO
Vehicle Damage	☐ Minimal – Moderate	☐ Severe - Totaled
	Was the vehicle towed away?	☐ YES ☐ NO
Police Report	☐ None	☐ Yes with Police Dept _____
Activities	☐ No restrictions	☐ Missed ____ days of work or school
	☐ I felt fine before the accident	

WORK RELATED or Other Injury Date _____ Time ____ [am] [pm] Location _____

Describe injury and how it happened:

_____

_____

_____

Accident Reported to _____ on _____(date)

☐ No restrictions ☐ Missed ____ days of work or school ☐ I felt fine before the injury

Patient Name: _____ ID#: _____ Date: _____

AUTO ACCIDENT QUESTIONNAIRE

Date of Accident _____ Brief description of accident _____

_____

Patient's vehicle (yr., make, model) _____ Ext. speed _____MPH

Patient's vehicle hit by _____ Ext. speed _____MPH

Time: ◻ Day ◻ Night ◻ Dawn ◻ Dusk Road Conditions: ◻ Dry ◻ Damp ◻ Wet

Did vehicle have seatbelts? ◻ No ◻ Yes Were seatbelts worn? ◻ No ◻ Yes ◻ Shoulder ◻ Lap

List (seat) position in vehicle _____

If vehicle had headrests, describe the position compared with top of your head:

◻ Top of headrest aligned with top of head ◻ Top of headrest aligned with middle of head

◻ Top of headrest aligned with bottom

Briefly describe the impact collision:

◻ Head on Collision ◻ Left Side Impact ◻ Right Side Impact ◻ Rear End Collision

List any parts of your body that made contact with vehicle parts _____

Hands: ◻ One on Wheel ◻ Two on Wheel

Were you braced for the impact? ◻ Yes ◻ No Were Brakes applied? ◻ Yes ◻ No

Were you looking up into inside rear view mirror? ◻ Yes ◻ No Was your car stopped? ◻ Yes ◻ No

Were you looking at outside door mirror? ◻ Yes ◻ No Loss of consciousness? ◻ Yes ◻ No

Wearing glasses? ◻ Yes ◻ No Still on? ◻ Yes ◻ No

Wearing hat? ◻ Yes ◻ No Still on? ◻ Yes ◻ No

Wearing dentures? ◻ Yes ◻ No Still in? ◻ Yes ◻ No

Estimated property damage: _____ ◻ Totaled ◻ Drivable ◻ Not Drivable

Others in car: # _____ Injured: ◻ Yes ◻ No Police on Scene? ◻ Yes ◻ No Report made: ◻ Yes ◻ No

Initial Symptoms: ◻ None ◻ HA ◻ Dizzy ◻ Disoriented ◻ Neck pain/stiff

◻ Nausea ◻ Vomiting ◻ Blurred Vision ◻ Ringing in ears ◻ Shock ◻ Back pain/stiff

◻ LBP/stiff ◻ Numbness / paresthesia 1st symptom appeared _____hr(s) after MVA.

Did you go to the hospital? ◻ Yes ◻ No Name of Hospital _____

If yes, when did you go to the hospital? ◻ Immediately ◻ Later, when _____

If yes, how did you get to the hospital? ◻ Ambulance ◻ Other _____

If admitted to hospital, how long did you stay? _____

At hospital: ◻ X-ray ◻ Lab ◻ RX ◻ Collar ◻ Other ◻ Follow Up instructions

Any medication prescribed? ◻ Yes ◻ No List name _____

Any previous motor vehicle accidents? ◻ Yes ◻ No Describe: _____

_____

If yes, was treatment rendered previously? ◻ Yes ◻ No Describe: _____

_____

Patient's Name _____ Case # _____ Date: _____

ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION
636 WEST BROADWAY, NORTH LITTLE ROCK, AR 72114
(501) 374-1153
FAX: (501) 374-6213

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay. Co-pays, deductibles and all non-covered services are due the day the service is rendered.
2. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
3. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
4. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
5. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $35.00 charge.
6. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.
7. I authorize APMR and or its agents to request information from credit reporting agencies for all purposes it deems necessary in order to collect on my account.
8. I authorize the use of my email address for appointment reminders, balance inquires or other promotional information from my doctor.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Acct #

_____ _____

Print Name of Patient

_____ _____

Signature (if minor, parent must sign) Date

ARKANSAS CENTER FOR PHYSICAL MEDICINE & REHABILITATION (501) 374-1153
636 West Broadway, North Little Rock, AR 72114 Fax: (501) 374-6213

RELEASE OF INFORMATION & PASSWORD

According to the Federal Government and the Privacy Act, this form will protect your private information from being given to anyone without prior permission.

Please provide us with a password that no one else will be able to identify. This password will give us security when contacting you or you contacting us for health or financial information. Please choose one of the following questions and provide us with an answer.

Thank you!

1) What is your mother's maiden name?

2) What street did you live on as a child?

3) What was the first car you owned?

_____ _____

Patient Signature: Date:

I hereby authorize the following person(s) to access any and all health information regarding my account. For example, this would include anyone such as a spouse or children. They will have to present the appropriate ID or know your password to obtain any information. Please list individuals below:

_____ _____

_____ _____

_____ _____

*****IF YOU CHOOSE NOT TO LIST ANYONE THEY WILL NOT BE ABLE TO OBTAIN ANY INFORMATION WITHOUT YOUR WRITTEN CONSENT*****

Patient ID#: _____

ARKANSAS PHYSICAL MEDICINE AND REHABILITATION
PATIENT CONFIDENTIAL HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

In order to offer you the best care, we need to understand your general health status. Please answer the following questions by checking the boxes as indicated:

ACCOUNT# _____

C	Current:	Currently has this condition
P	Previously:	Had the condition in the past but does not have any problem now
N	Never:	Never had the condition

GENERAL

	C	P	N	
1.	☐	☐	☐	Fever
2.	☐	☐	☐	Chills
3.	☐	☐	☐	Night Sweats
4.	☐	☐	☐	Loss if Sleep
5.	☐	☐	☐	Fatigue
6.	☐	☐	☐	Nervousness
7.	☐	☐	☐	Weight Loss or Gain
8.	☐	☐	☐	Allergies
9.	☐	☐	☐	Bleeding Problem
10.	☐	☐	☐	Anemia
11.	☐	☐	☐	Diabetes
12.	☐	☐	☐	Cancer
13.	☐	☐	☐	Thyroid Disease/Goiter
14.	☐	☐	☐	Alcoholism
15.	☐	☐	☐	Drug Abuse

EAR, EYE, NOSE, THROAT

	C	P	N	
16.	☐	☐	☐	Poor Vision
17.	☐	☐	☐	Eye Pain
18.	☐	☐	☐	Hearing problems
19.	☐	☐	☐	Nosebleeds
20.	☐	☐	☐	Nose problems
21.	☐	☐	☐	Sinus trouble
22.	☐	☐	☐	Dental Problems
23.	☐	☐	☐	Hoarseness
24.	☐	☐	☐	Tonsillectomy

RESPIRATORY

	C	P	N	
25.	☐	☐	☐	Difficulty in Breathing
26.	☐	☐	☐	Shortness of Breath
27.	☐	☐	☐	Chronic cough
28.	☐	☐	☐	Spitting Phlegm
29.	☐	☐	☐	Spitting Blood
30.	☐	☐	☐	Wheezing/Asthma
31.	☐	☐	☐	Pneumonia
32.	☐	☐	☐	Tuberculosis

CARDIOVASCULAR

	C	P	N	
33.	☐	☐	☐	Irregular heart Beat
34.	☐	☐	☐	High Blood Pressure
35.	☐	☐	☐	Chest Pain
36.	☐	☐	☐	Heart Problems
37.	☐	☐	☐	Ankle Swelling
38.	☐	☐	☐	Varicose Veins
39.	☐	☐	☐	Rheumatic Fever
40.	☐	☐	☐	Stroke

SKIN

	C	P	N	
41.	☐	☐	☐	Itching
42.	☐	☐	☐	Bruising Easily
43.	☐	☐	☐	Change in Mole(s)
44.	☐	☐	☐	Skin Cancer
45.	☐	☐	☐	Hair/Nail Changes
46.	☐	☐	☐	Scar(s)

GASTROINTESTINAL

	C	P	N	
47.	☐	☐	☐	Poor Appetite
48.	☐	☐	☐	Poor Digestion
49.	☐	☐	☐	Difficulty Swallowing
50.	☐	☐	☐	Belching or Gas
51.	☐	☐	☐	Frequent Nausea/Vomiting
52.	☐	☐	☐	Vomiting Blood
53.	☐	☐	☐	Pain Over Abdomen
54.	☐	☐	☐	Stomach Ulcer
55.	☐	☐	☐	Black or bloody Stool
56.	☐	☐	☐	Liver Problems
57.	☐	☐	☐	Gall Bladder Problems
58.	☐	☐	☐	Jaundice
59.	☐	☐	☐	Diarrhea
60.	☐	☐	☐	Constipation
61.	☐	☐	☐	Bloating
62.	☐	☐	☐	Hemorrhoids
63.	☐	☐	☐	Appendicitis
64.	☐	☐	☐	Hernia

GENITOURINARY

	C	P	N	
65.	☐	☐	☐	Frequent Urination
66.	☐	☐	☐	Painful Urination
67.	☐	☐	☐	Blood in Urine
68.	☐	☐	☐	Urinary Tract Infection
69.	☐	☐	☐	Kidney Disease
70.	☐	☐	☐	Kidney Stones
71.	☐	☐	☐	Inability to Control Urination
72.	☐	☐	☐	Difficulty Starting Urination
73.	☐	☐	☐	Get up at Night to Urinate
74.	☐	☐	☐	Sexually Transmitted Disease
75.	☐	☐	☐	Sexual Difficulties

76. Date of Last Colonoscopy _____

MEN ONLY

	C	P	N	
77.	☐	☐	☐	Testicular Problems
78.	☐	☐	☐	Prostate Problems

79. Date of Last Prostate Exam _____

WOMEN ONLY

	C	P	N	
80.	☐	☐	☐	Painful Periods
81.	☐	☐	☐	Excessive Flow
82.	☐	☐	☐	Irregular Cycles
83.	☐	☐	☐	Vaginal Burning/Itching
84.	☐	☐	☐	Hot Flashes

85. Date of last Menstrual Period _____

86. Date of Last Pap Smear _____

FOR MEN AND WOMEN

87.	☐	☐	☐	Breast Lump or Pain

For each response, Past or Current, indicate the item # and give a description of the problem including duration, number of episodes and treatment received.

NEUROLOGIC

	C	P	N	
88.	☐	☐	☐	Weakness
89.	☐	☐	☐	Twitching
90.	☐	☐	☐	Tremor
91.	☐	☐	☐	Headache
92.	☐	☐	☐	Fainting
93.	☐	☐	☐	Dizziness
94.	☐	☐	☐	Convulsions
95.	☐	☐	☐	Epilepsy/Seizures
96.	☐	☐	☐	Numbing/Tingling
97.	☐	☐	☐	Arm/leg Pain
98.	☐	☐	☐	Mental disorder

MUSCULOSKELETAL

	C	P	N	
99.	☐	☐	☐	Neck Stiffness/Pain
100.	☐	☐	☐	Pain between Shoulders
101.	☐	☐	☐	Low Back Pain
102.	☐	☐	☐	Painful Joints
103.	☐	☐	☐	Muscle Ache/Soreness
104.	☐	☐	☐	Spinal Curvature
105.	☐	☐	☐	Arthritis

EXERCISE

	C	P	N	
106.	☐	☐	☐	None
107.	☐	☐	☐	1-2 Times a Week
108.	☐	☐	☐	3-5 Times a Week
109.	☐	☐	☐	6-7 Times a Week

HABITS

	C	P	N	
110.	☐	☐	☐	Smoking # Packs/day____
111.	☐	☐	☐	Drinking (Alcohol)
112.	☐	☐	☐	Recreational Drug Use
113.	☐	☐	☐	Caffeine
114.	☐	☐	☐	Soft Drinks
115.	☐	☐	☐	Artificial Sweeteners

TRAUMA

Indicate if you ever had or been involved in any of the following

	Yes	No	
116.	☐	☐	Car accident
117.	☐	☐	Major fall
118.	☐	☐	Broken bones
119.	☐	☐	Head Trauma
120.	☐	☐	Sports

FAMILY HISTORY

Include Information on Brothers, Sisters, Parents, and Grand Parents.
(Do not include yourself)

121.	☐	Diabetes
122.	☐	Thyroid Disease/Goiter
123.	☐	Tuberculosis
124.	☐	Kidney Disease
125.	☐	High Blood Pressure
126.	☐	Heart Disease
127.	☐	Cancer
128.	☐	Muscle, Bone, or Nerve Disease
129.	☐	Lung Disease
130.	☐	Ulcer
131.	☐	Arthritis
132.	☐	Seizure/Stoke

Medications(s): _____

Nutritional Supplements: _____

Past Chiropractic History: _____

PATIENT SIGNATURE: _____ DATE: _____

REVIEWED BY ATTENDING PHYSICIAN: _____ DATE: _____

ARKANSAS PHYSICAL MEDICINE & REHABILITATION

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A. Complete for All Authorization

I hereby authorize the use or disclosure of my individually identifiable health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive my Phi is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Patient name:_____ ID Number:_____

Persons/organizations authorized to release your PHI

_____

_____

_____

Persons/organizations authorized to receive your PHI

_____

_____

_____

Specific description of PHI to be released (including date(s)):_____

_____

_____

_____

Specific regulations you want placed on release of your PHI:_____

_____

I understand that this authorization will expire on-____/____/____ (DD/MM/YR) Initials:_____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation. Initials:_____

Section B. Complete if Release is Requested by Health Care Provider

(To be completed by Provider Before Signature by Patient)

_____ Request For Own Use _____ Request For Use And Disclosure By Another Provider/Plan

The use or disclosure for which this request is made is _____

_____

As the Provider, we will not receive financial or other compensation in exchange for using or disclosing health information described above.

(To be Completed by Patient Before Signing)

I understand that I am not required to sign this authorization form. Initials:_____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_____

I understand that I may see and copy the PHI to be released pursuant to this form if I so request, and that I will receive a copy of this form after I sign it. Initials:_____

Section C. Complete for All Authorizations

_____

Signature of patient or patient's representative (Form MUST be completed before signing.) **Date**

Printed name of patient's representative: _____

Relationship to the patient:_____

INSURANCE SECURITY AGREEMENT
&
LETTER OF PROTECTION

1. **Insurance credit application:**

Patient: _____ hereby applies to:
Dr. Steven F. Bennett and Arkansas Physical Medicine and Rehabilitation, 636 Broadway, North Little Rock, Arkansas 72114, telephone (501) 374-1153; Fax (501) 374-6213 (herein called **Medical Provider**);
for secured insurance credit regarding all medical bills that were caused by the injury accident that occurred on _____, 201__.

2. **Insurance secured credit:**
The person(s) and/or business(es) responsible for causing my injuries is/are covered by insurance. The Insurance companies responsible for ultimately paying for the cost of the medical care are:

_____(herein called "insurance company").

Patient authorizes said Medical Provider to send Patient's medical records and bills for payment to:

(a) each of said person(s) and/or business(es),
(b) to the insurance company that insures each of them, and
(c) to the Patient's medical insurance company, if any, that covers Patient's injuries from this accident.

To further provide insurance-security to said Medical Provider, Patient promises to file a lawsuit against any person or business covered by liability insurance and/or their insurance company that denies payment, in whole or in part, for Patient's medical bills.

3. **Attorney representation to secure payment of medical bills by insurance company:**
(a) Patient understands that Patient may have to hire an attorney to secure payment from an insurance company, and if so, Patient authorizes and directs said attorney to promptly sign this agreement.
(b) Patient authorizes Medical Provider to send medical records, reports, and bills to said attorney.
(c) Patient authorizes and directs the Patient's attorney, if any, or the insurance company to give to Medical Provider from the insurance settlement or recovery an amount to pay Patient's medical bills in full, promptly upon a settlement or recovery being received.

4. **Charges for medical services**:
Medical Provider promises to bill a reasonable and customary amount for all medical services provided, and agrees to send a copy of all bills to Patient and/or Patient's attorney.

5. **Assignment of benefits and Lien:**
Patient directs his/her attorney to withhold the full amount of the medical bills and services, including those for treatments heretofore and thereafter rendered, as well as for any reports; coping fees; liens; filing fees; (and any monies/balances due from depositions, court appearances or standby court appearance fees) from any recovery obtained from insurance company and/or responsible party(ies) via settlement, arbitration or court determination and, within 14 days of receipt, to send payment Directly to Medical Provider. Patient gives Physician a lien on such recovery to secure payment of all medical bills and services. Patient agrees that this assignment of benefits, grant of a medical lien and execution of this agreement are irrevocable, and cannot be withdrawn or changed by Patient in the future.

6. **Patient responsibility:**
Patient understands and agrees that Patient is 100% directly and fully responsible to pay Medical Provider for all medical services rendered and bills issued pursuant to this Insurance Security Agreement:

(a) Even if any insurance company denies payment in whole or part for such medical services;
(b) Even if Patient is forced to file a lawsuit due to denial of payments by an insurance company; and
(c) Even if a judge, jury, or arbitrator renders a decision in Patient's lawsuit or claim that the insurance company for said person or entity is not responsible for payment of Patient's medical bills.

Patient agrees to comply with any payment plan agreement that may be made between Patient and Medical Provider.

7. **Lawsuit to collect debt:**
If insurance company does not pay this insurance secured credit and the Patient fails to pay 100% for all medical services provided, and a lawsuit is filed against Patient to collect the medical bills, the prevailing party shall be entitled to recover reasonable attorney's fees and costs of suit according to law. In consideration of Medical Provider filing insurance claims verses payment in full, patient waives the benefit of the statute of limitations as a defense to any debt collection lawsuit that may be filed by Medical Provider against Patient in the future to collect medical bills and services now owed or hereafter incurred.

8. **Insurance security agreement & Letter of Protection by attorney:**
(a) Person(s) and/or business(es) that caused and/or are legally responsible for said Patient's injuries is/are covered by liability insurance.
(b) Patient promises to send all medical bills, reports, and records to said insurance company for payment.
(c) Patient agrees to be fully bound by all of the terms and conditions stated in this Insurance Security Agreement and Letter of Protection.
(d) Patient agrees to withhold full payment for all medical bills from any recovery and send full payment to Medical Provider within 14 days of disbursement of any money received from recovery.
(e) In the event of substitution of attorneys, Patient agrees to notify the new attorney and Medical Provider of any substitution of attorneys and to direct the new attorney to sign this Insurance Security Agreement and Letter of Protection.

9. **Facsimile:**
It is agreed that a fax copy shall have the same validity as the original hereof.

Dated this ____ day of _____, 201__.

By Patient: _____

By Medical Provider: _____

By Patient's Attorney: _____

Digital *motion* X-ray®
is available at

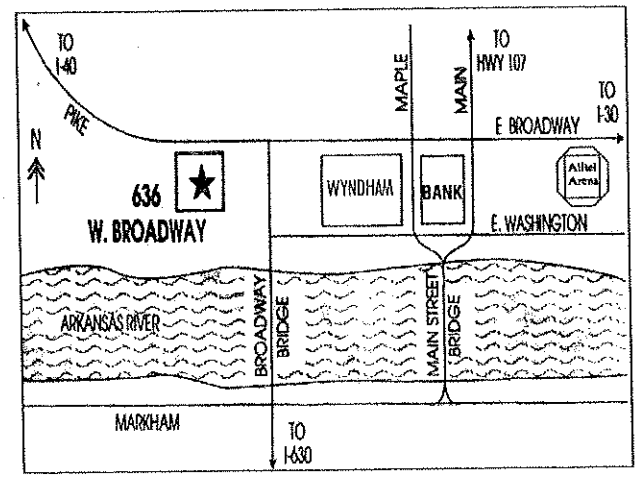
APMR
Arkansas Center for Physical Medicine & Rehabilitation

Location

FROM North Little Rock & Sherwood
Take Interstate 40 to Interstate 30 (towards downtown Little Rock). Get off I-30 at the Broadway exit. Go 2 blocks to the traffic light. Turn right on Broadway (at the Alltell Arena), go through 4 more traffic lights (approx. 1 mile). At the 4th traffic light continue straight ahead. We are one block from this traffic light on the left. We are next to "Superior Spring".

FROM West Little Rock
Take I-630 East. Get off at the Broadway exit. Turn left on Broadway (go through downtown Little Rock). Go over the Broadway Bridge (over the Arkansas River) to North Little Rock. At the traffic light at the foot of the Broadway Bridge (on the North Little Rock side) turn left. We are one block from the bridge on the left.

FROM South & Southwest Little Rock
Take I-30 North over the Arkansas River. Get off at the Broadway exit. Turn left under the freeway. Go past the Alltell Arena. Go through 4 more traffic lights (approx. 1 mile). At the 4th traffic light continue straight ahead. We are one block from this traffic light on the left. We are next to "Superior Spring".



636 WEST BROADWAY
NORTH LITTLE ROCK, ARKANSAS
ph: (501) 374-1153 • fax: (501) 374-6213