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(407) 658-1719
Fax (407) 658-2536

KISSIMMEE OFFICE
3315 Orange Blossom Trail
Kissimmee, FL. 34746
(407) 343-1919
Fax (407) 343-1907

ADULT PATIENT INFORMATION

Patient Name: _____ _____ _____
First Name **MI** **Last Name**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Cell Phone #:** _____ **Social Security:** _____

Date of Birth:_____ **Age:**_____ **Male** ☐ **Female** ☐ **Marital Status:** _____

Name of Employer: _____

Employer Phone #: _____ **Occupation:** _____

Employer Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Person Responsible for Bill: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Phone #:** _____ **Social Security:** _____

Emergency Contact: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Relationship:** _____

Please Mark all that Applies for you: ☐ **Insurance** ☐ **W/C** ☐ **Medicaid** ☐ **Self-pay**

Primary Insurance: _____ **Phone #:** _____

Claim Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit/ Debit Card**

PAYMENT IS REQUIRED AT TIME OF SERVICE

I authorize Urgentmed to release information regarding my examination or treatment for the purpose of obtaining insurance compensation, precertification, or medical records. I authorize payment of medical benefits to Urgentmed when claim forms are filed upon my behalf for treatment. Also, I give authorization for medical treatment. All invoices must be paid within terms quoted. I understand that I am responsible for the bill if my insurance does not pay within 30 days.

Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date	Initial	Reason:

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ADULT HEALTH HISTORY FORM

Patient Name: _____ Date: _____
Purpose of Initial Visit: _____

ALLERGIES

Drugs: _____

Food: _____

Other: _____

CURRENT MEDS:

Prescription: □ No □ Yes Please List:
_____
_____
_____

Over the Counter: □ No □ Yes Please List:
_____

FAMILY HISTORY

Use √ Marks for Yes Answers:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Cancer						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Thyroid Disease						
Drug Addiction						
Alcohol Addiction						
Other:						

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please check if you have had problems with or are presently complaining of any of the following:

- o High Blood Pressure
- o Diabetes
- o Cancer
- o Heart Disease
- o Chest Pain/ Chest Tightness
- o Short of Breath
- o Swollen Ankles
- o Palpitations
- o Lightheadedness
- o Frequent Urination
- o Rheumatic Fever
- o Asthma
- o Bronchitis
- o Pneumonia
- o Persistent
- o Tuberculosis
- o Abdominal Discomfort
- o Hay Fever
- o Indigestion
- o Nauseous
- o Vomiting
- o Constipation
- o Diarrhea
- o Blood in Stool
- o Ulcers
- o Gout
- o Hemorrhoid
- o Gall Bladder Disease
- o Unexplained Weight Gain/Loss
- o Colitis
- o Hepatitis or Jaundice
- o Thyroid Disease
- o Head or Neck Radiation
- o Headache
- o Kidney Disease
- o Kidney Stones
- o Difficulty urinating
- o Arthritis
- o Low Back Problems
- o Skin Diseases
- o Blood Disorders
- o Venereal Diseases
- o Anxiety
- o Depression
- o Anemia
- o Alcohol Abuse
- o Drug Abuse
- o Change in Bowel Habits
- o _____
- o _____
- _____

PLEAST LIST AND SUPPLY THE DATES OF:
Operations ☐ No ☐ Yes Please List: _____
_____
_____

Hospitalizations Other than for Surgery: ☐ No ☐ Yes Please List: _____
_____

Transfusions: No ☐ Yes ☐ Please List: _____
_____

IMMUNIZATION HISTORY- HAVE YOU HAD:

Pneumovax Immunization? □ No □ Yes When? _____
Hepatitis B? □ No □ Yes When? _____
Flu Immunization? □ No □ Yes When? _____
Tetanus? No □ Yes □ When? _____
Other? No □ Yes □ When? _____

WHEN WAS YOUR LAST:

Complete Physical	Date: _____	Results: _____	TB Test	Date: _____	Results: _____
Cholesterol Check	Date: _____	Results: _____	PAP Test	Date: _____	Results: _____
Eye Exam	Date: _____	Results: _____	Mammogram	Date: _____	Results: _____
Hearing Test	Date: _____	Results: _____	Breast Exam	Date: _____	Results: _____
Stool Check for Blood	Date: _____	Results: _____	Prostate Exam	Date: _____	Results: _____

FOR WOMEN ONLY GYNECOLOGICAL AND OBS HISTORY

Age at onset of Periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: ☐ Births: ☐ Miscarriages: ☐ Abortions: ☐

Prolonged or Abnormal Bleeding: ☐ No ☐ Yes Please Describe: _____

Leakage of Urine: ☐ No ☐ Yes Please Describe: _____

History of Abnormal PAP Smear: ☐ No ☐ Yes Type of Treatment: _____

PREVENTION

Do you wear seat belts? ☐ No ☐ Yes If no, why not? _____

Do you wear a bike helmet? ☐ No ☐ Yes If no, why not? _____

Do you drink beverages with caffeine? ☐ No ☐ Yes If yes, how many per day? _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much per week? _____

Do you use drugs? (Marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: _____

_____

Is there a gun in your home? ☐ No ☐ Yes

Is it unloaded and out of children's reach? ☐ No ☐ Yes ☐ N/A

RISK HISTORY

Currently sexually active? ☐ No ☐ Yes]How many partners in the past 5 years? ☐

HAVE YOU EVER EXPERIENCED:

Sex with injecting drug user? ☐ No ☐ Yes Sex with person with HIV/AIDS Risk? ☐ No ☐ Yes

Sex with same-sex partner(s)? ☐ No ☐ Yes Sex for drugs/money? ☐ No ☐ Yes

Sex while using drugs? ☐ No ☐ Yes Ever been a victim of sexual assault? ☐ No ☐ Yes

CONTRACEPTIVE METHOD LAST USED/NOW USING:

History-Other methods used: _____

Problem(s) with methods: _____

Have you been in contact with person with confirmed TB? ☐ No ☐ Yes If yes, explain: _____

_____

Are you from or have you recently traveled to regions of the world with high TB prevalence? ☐ No ☐ Yes If yes, explain: _____

_____

Are you in contact with the following: HIV + person, Migrant farm workers, Residents of nursing homes, Institutionalized/ Incarcerated person, Homeless persons, IV/street drug users, etc. ☐ No ☐ Yes If yes, explain: _____

_____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain: _____

_____

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, etc.) by your partner? ☐ No ☐ Yes ☐ N/A

Do you feel afraid of your partner? ☐ No ☐ Yes

Do you have a "living will"? ☐ NO ☐ Yes (if yes, please provide a copy)

Do you have a donor card? ☐ No ☐ Yes

SIGNATURE: _____ PRIMARY LANGUAGE: _____

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PATIENT THERAPY TREATMENT LOG

Patient's Name: _____ Date of Birth: _____

VISIT NO.	DATE	TREATMENT	PATIENT'S SIGNATURE
1		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
2		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
3		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
4		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
5		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
6		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
7		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
8		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
9		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
10		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
11		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
12		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
13		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
14		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
15		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
16		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
17		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
18		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
19		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	
20		Electrical Stim/Massage/Hot or Cold Packs/Ultrasound	

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MEDICAL PROBLEMS SUMMARY SHEET

Patient's Name: _____ Date of Birth: _____

Medical Problems	Medications Maintenance
Surgeries/Injuries	

Annual Screening	Dates	Dates	Dates	Dates	Dates
Pap Smear					
Bone Density					
Cholesterol LDL Screening					
Colorectal Screening (Gualac)					
HbA1c (Diabetic Screening)					
Mammogram					
Optometry DM Screening					
PSA Screening					

URGENTMED CARE
WALK-IN CLINIC

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Date: _____

To whom it may concern,

This letter is to inform you that UrgentMed Care, Tax ID: 593543941, will be providing medical care for patient:

Patient Name: _____

Claim Number: _____

Date of Accident: _____

Patient Address: _____

_____

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ASSIGNMENT OF INSURANCE BENEFITS

Date: _____

Name: _____

Date of Birth: _____

SS#: _____

Date of Accident: _____

Claim #: _____

I, _____ assign UrgentMed Care all rights, benefits and cause of accident for personal injury protection and medical payment benefits available to me under the policy issued by _____ Insurance Company for medical claims resulting from an automobile accident, which occurred on _____. Insurance payments shall be made directly to UrgentMed Care, 716 S. Goldenrod Road, Orlando, FL. 32822. Tax ID for Mohammed H. Bawany, MD., PA. DBA UrgentMed Care. Tax ID # 593543941

Patient's Signature: _____ Date: _____

The undersigned hereby accepts assignments of insurance benefits for services to the patient named above. Payments are made directly to UrgentMed Care under personal injury protection (PIP) and all medical payments benefits are covered with _____.

Insurance Company In accordance with Florida Statute # 627-7-36- (5)

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DISCLOSURE AND ACKNOWLEDGEMENT FORM
COMPLIANCE WITH SECTION 627.736 (S) (e) FLORIDA STATUES

RE: Patient Name: _____ D.O.B: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Work #: _____

Auto Insurance Name: _____

Name of Insured: _____

Claim No: _____ Date of Injury: _____

Policy No: _____ Insurance Phone #: _____

This form is being completed persuant to section 627.736 (S) (e), Florida for payment of PIP benefit. I, _____, understand and acknowledge that I have the right and affirmative duty to confirm that health care services were actually rendered to me by Urgentmed Care. I acknowledge that I was not solioited by any person for the service rendered to me. I acknowledge that the service listed in the travel card/CMS 1500 form were actually rendered to me on _____ and that the services were explained to me. I furthure understand that I notify insurer in writing of a billing error, I may be entitled to a certain percentage of a reduction in the amount paid by the insurer.

I have signed this form freely and with my informed consent.

_____ _____

Patient Signature Date

_____ _____

Provider Signature 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 Statues

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IRREVOCABLE DOCTORS LIEN

File Name: _____

Attorney/ Contact: _____

Patient: _____

I hereby authorize UrgentMed Care Walk-In Clinic to furnish you, my attorney, with a full report of theirr examination, diagnosis, treatment, prognosis, ect. Of myselft in regard to the accident in which I was involved.

I hereby authorize and direct you, my Attorney, to pay directly to said doctor such sums as may be due and owing him/her office and to with-hold such sums for any settlement, judgement, or verdict as may be necessary adequately to protect said doctor. I herey furthur given a lien on my case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection there with.

I fully understand that I am directly responsible to said doctor for all professional bills submitted by him/her for services rendered to me and this agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. I furthur understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

I have been advised that if my attorney does not cooperate, the doctor will not await payment but may delcare the entire balance due and payable.

Patient Signature: _____ Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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.**

Office Visits, Labs, X-Rays, Physical Therapy

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	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.

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Pub. 1/2004

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PIP INSURANCE VERIFICATION FORM

PATIENT NAME: _____

DOB: _____

AUTO INSURANCE: _____

INSURANCE PHONE NUMBER: _____

CLAIM NUMBER: _____

DOA: _____

ADJUSTER'S NAME: _____

ADJUSTER'S PHONE NUMBER: _____

INSURANCE BILLING ADDRESS:

_____

_____

_____

ELIGIBLE FOR PIP BENEFITS: **YES** ☐ **NO** ☐

VERIFICATION DATE: _____

VERIFIED BY: _____

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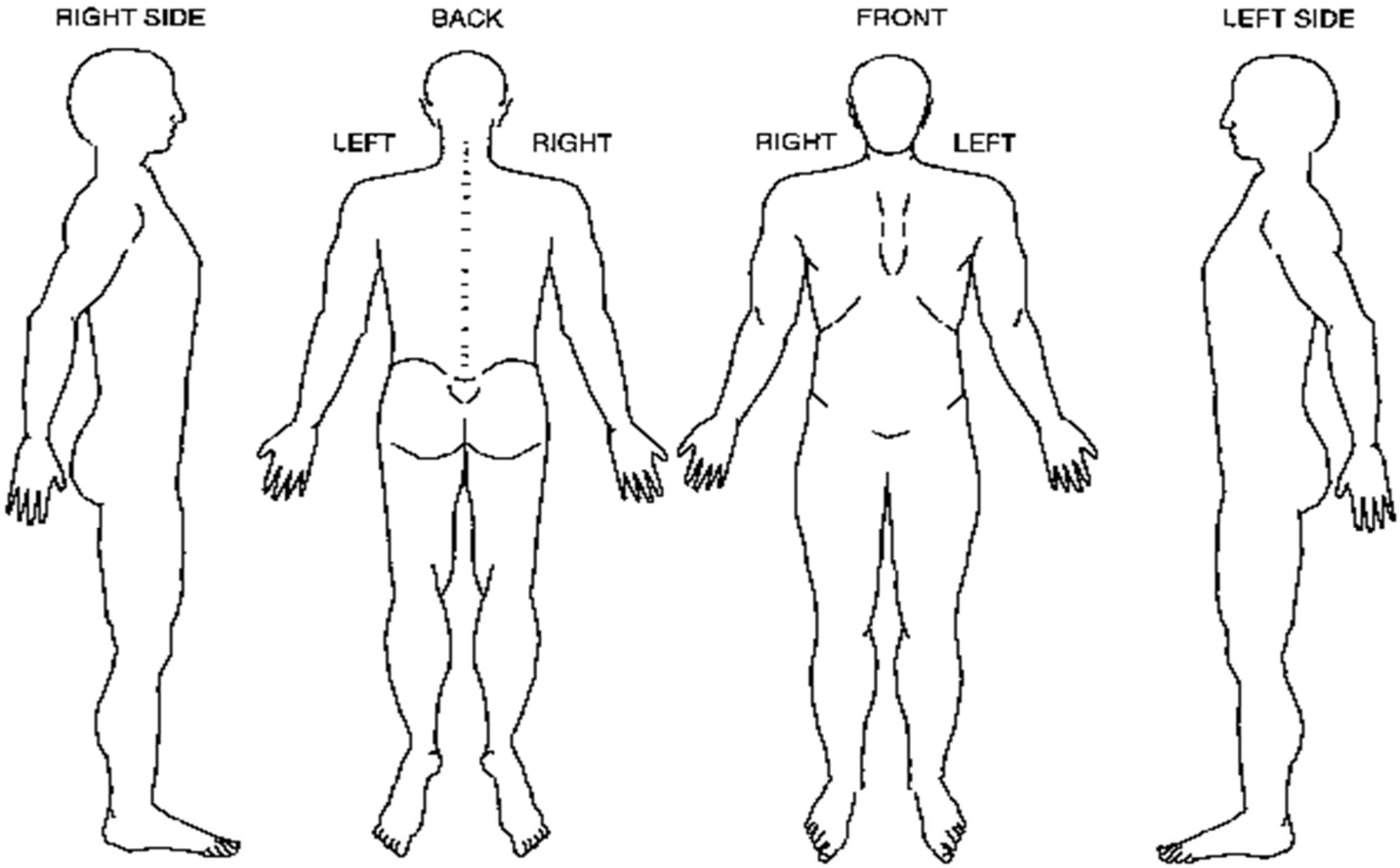
PAIN CHART

Patient: _____ Date: _____/_____/_____

Please mark the body area(s) of pain or injury utilizing the following symbols:

Symptom(s):	Aching	Numbness	Burning	Stabbing	Cramping	Pain
Symbol:	AAA	NNN	BBB	SSS	CCC	PPP

*Circle any area of pain not represented by a symbol.



Patient Signature: _____