01

Welcome to Tropical

Please complete each section by hand. Print clearly and mark the appropriate checkboxes.

4243 NW Federal Hwy, Jensen Beach, FL 34957
(888) 9TROPICAL | Local: (772) 419-9123 | care@tropicalmedicalgroup.com

Today's date _____ **Patient is a minor? (Yes / No)** _____

Patient information

Full name _____

Date of birth _____ **Gender** _____ **Race** _____ **Social Security number** _____

Street address _____

City _____ **State** _____ **ZIP code** _____

Cell phone _____ **Home phone** _____ **Work phone** _____

Email address _____

Parent / guardian information

Complete if applicable

Name _____ **Date of birth** _____ **Social Security number** _____

Street address _____

City _____ **State** _____ **ZIP code** _____

Cell phone _____ **Home phone** _____ **Work phone** _____

Email address _____

Emergency contact name _____ **Emergency contact phone** _____

02 Accident & initial care

Tell us about your accident and the care you have received so far.

Accident details

Date of accident

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Slip & fall

☐ Driver ☐ Front seat passenger ☐ Back seat passenger

Were you wearing a seat belt? ☐ Yes ☐ No

Hospital & early treatment

Did you go to the hospital? ☐ Yes ☐ No

If yes, which hospital?

Did you go by ambulance? ☐ Yes ☐ No

Were you admitted? ☐ Yes ☐ No

Discharge date

Have you received prior therapy? ☐ Yes ☐ No

Did you see a physician within 14 days of the accident? ☐ Yes ☐ No

Chiropractor name

Are you able to work? ☐ Yes ☐ No

03 Coverage & care team

Provide your insurance information and the contacts involved in your care.

Auto insurance

Auto insurance company

Name of insured

Policy number

Claim number

Attorney information

Attorney / firm name

Phone number

Case manager name

Health insurance

Do you have health insurance? ☐ Yes ☐ No

Health insurance company

Name of insured

Policy number

Group number

Your care team

Primary care doctor

Preferred pharmacy

04 Symptoms & prior care

Your answers help your clinician understand your pain and treatment history.

Pain levels

Enter 1-10; leave blank if no pain

1 = Very little pain ● ● ● ● ● ● ● ● ● ● **10 = Excruciating**

Head		Tailbone	
Neck		Right hip	
Mid-back		Left hip	
Low-back		Right leg	
Right shoulder		Left leg	
Left shoulder		Right knee	
Right arm / elbow		Left knee	
Left arm / elbow		Right foot / ankle	
Right hand / wrist		Left foot / ankle	
Left hand / wrist		Other (please list)	
Other			

Is pain affecting your ability to sleep? ☐ Yes ☐ No

☐ Constant ☐ Intermittent ☐ Worsening ☐ Improving ☐ Unchanged

☐ Pain ☐ Stiffness ☐ Swelling ☐ Instability ☐ Weakness ☐ Numbness / tingling

What makes it worse?

What makes it better?

Previous formal treatment (medications, therapy, surgery, injections)

Past surgical history

Previous type of operation	Year

05 Medications & allergies

Include all medications, aspirin, vitamins, and other supplements you currently take.

Fractures & drug allergies

Have you had any previous fractures? ☐ Yes ☐ No

If yes, where?

Do you have any drug allergies? ☐ Yes ☐ No

If yes, name the drug and reaction (for example: rash or nausea)

Current medications

Medication / drug name	Reason for use	Strength & frequency	Start date

06 Medical history

For each condition, mark Yes or No. Add details in the fields where requested.

GENERAL

	YES	NO
Currently pregnant	☐	☐
Diabetes	☐	☐
Type 1 / Type 2		
Stroke	☐	☐
Kidney disease	☐	☐
Ulcers	☐	☐
Asthma or lung disease	☐	☐
Cancer	☐	☐
Type		
Fatigue	☐	☐
Weakness	☐	☐
Fevers	☐	☐
Skin problems	☐	☐
Type		
Rheumatic fever	☐	☐
Tuberculosis	☐	☐
Recent weight gain / loss	☐	☐
How much?		

CARDIOVASCULAR

	YES	NO
Chest pain / angina	☐	☐
Heart attack / myocardial infarction	☐	☐
Palpitations	☐	☐
High blood pressure / hypertension	☐	☐
Shortness of breath	☐	☐
Swelling of lower extremities	☐	☐

HEMATOLOGIC

	YES	NO
Anemia	☐	☐
Blood clots	☐	☐
Bleeding tendency	☐	☐
Easily bruised	☐	☐
Circulatory problems	☐	☐
Taking blood thinners	☐	☐
If yes, what type?		
Phlebitis	☐	☐

07 Medical history, continued

For each condition, mark Yes or No.

NEUROLOGICAL

	YES	NO
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Memory loss	☐	☐
Loss of consciousness	☐	☐
Muscle spasm	☐	☐
Numbness / tingling in hands / feet	☐	☐
Trouble seeing / blindness	☐	☐
Trouble hearing / deafness	☐	☐
Seizures	☐	☐

MUSCULOSKELETAL

	YES	NO
Joint pain	☐	☐
Joint swelling	☐	☐
Muscle tenderness	☐	☐
Morning stiffness	☐	☐
Arthritis / osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐
Bone / joint infection	☐	☐
Gout	☐	☐

BLOODBORNE

	YES	NO
HIV / AIDS	☐	☐
Hepatitis	☐	☐
Other	☐	☐

INFECTION SITE

	YES	NO
Urinary	☐	☐
Dental	☐	☐
Other	☐	☐

PSYCHOLOGICAL

	YES	NO
Depression	☐	☐
Anxiety disorder	☐	☐
Stress	☐	☐

08 Family & daily life

Tell us about your family history and daily activities.

Family history

Parents, siblings, or grandparents

Diabetes	☐ Yes	☐ No	Abnormal bleeding tendencies	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Anesthetic complications	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Gout	☐ Yes	☐ No

Cancer type, if applicable

Social history

Occupation **Job duties**

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children

Do you smoke? ☐ Yes ☐ No

If yes, packs per day **Year started**

Have you been counseled to quit or cut down? ☐ Yes ☐ No

If you do not smoke now, are you a former smoker? ☐ Yes ☐ No

Former smoker: year started **Year quit**

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many drinks per week?

I, as the patient, state the information is correct and accurate to the best of my knowledge.

Patient / parent or legal guardian signature **Date**

09 Authorizations

Read each section and enter your initials in the corresponding field.

Patient name

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-rays and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252 F.S.) . I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. You are authorized to provide this information in accordance with the automobile personal injury protection law. (Chapter 71-252 F.S)

Initials

Consent for Treatment

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to and authorize the administration of the medical treatment that may be considered advisable or necessary in the judgment of the physician. I hereby authorize the above company to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

Initials

Notice of Privacy Practices acknowledgment

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Initials

Payment Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Tropical Medical Group, LLC, will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly to Tropical Medical Group, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable.

Initials

10 Benefits & payment

Read each section, initial where shown, and sign the agreement below.

Assignment of Benefits

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Tropical Medical Group, LLC for payment for services rendered unto me due to accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument all rights and causes of action in tort, in contract, and under the laws of Florida, against the personal injury protection carrier for the above named insured patient for its failure to pay for services rendered unto me by Assignee in relation to my accident or illness. This assignment may only be rescinded / reassigned by the mutual consent of the patient / insured / assignor and the health care provider / assignee.

Initials _____

Reservation of Benefits

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

Initials _____

Direction of Payment / Release of Information

I hereby authorize any auto insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of insurance or declaration sheet, which reflects the applicable policy limits available at the time of this accident, to be provided by the insurance company to the Assignee. I hereby authorize Assignee the permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

Initials _____

Signature agreement

I, _____, hereby consent and agree to all terms of this Agreements and Authorization section and have freely provided my initials for the terms therein.

Patient / parent or legal guardian signature _____ **Date** _____

11 Health insurance waiver

Waiver of Health Insurance Agreement

Patient name

If you are a patient seeking treatment for an injury arising from an automotive accident or a tort action, you will be considered an automotive or legal patient throughout the course of your treatment. You have requested and chosen for us NOT to bill any insurance or other payment entity, and agree to be responsible for reasonable charges. By seeking treatment from Tropical Medical Group, LLC, you agree as follows:

1. To forego submission of claims to your health insurance for covered items or services.
2. To be responsible for payment of such items or services and understand that no reimbursement will be provided by your health insurance.
3. That no limitations on charges from health insurance fee schedules are applicable to amounts that may be charged for items and services provided.
4. That Medigap plans and other supplemental insurance plans may elect not to make payments for such items and services because payment is not made from your primary health insurance.
5. That you have the right to have such items or services provided by other physicians or practitioners for whom payment would be made from health insurance.

Should surgery or extensive treatment be required, as a courtesy to you and for your convenience, we will obtain the necessary authorization through your health insurance should you request it. However, that does not constitute a waiver of this Agreement by Tropical Medical Group, LLC.

By signing this, you agree that you fully read and understand the contents of this Agreement.

Patient signature **Date**

Doctor's signature **Date**



12 Medical lien agreement

Irrevocable Medical Lien Agreement

Patient name _____ **Date of birth** _____

Street address _____ **City / State / ZIP** _____

Social Security number _____

I, _____ (the "Patient"), hereby acknowledge and agree that I am financially responsible for all medical services provided to me by Tropical Medical Group, LLC ("Provider"). In consideration of the medical services rendered by the Provider, I agree as follows:

1. I understand and agree that I am personally responsible for any and all medical charges billed by the Practice for my treatment and that if at any time, I default on this obligation, I am subject to collection actions and/or civil litigation instituted by the Practice to recover the above medical debt. My obligation under this Agreement stands alone and is not subject to any other contingency or occurrences.

2. All treatment administered by the Provider is deemed medically necessary care and treatment and will be billed at their usual and customary rate.

3. I understand that the Provider may impose interest on any unpaid balance at the rate of 5% per annum, or the maximum rate allowed by Florida law, whichever is less.

4. I understand the Provider agrees to defer the collection any billing for medical care and treatment provided to me for 24 months without interest.

5. I agree that in the event I fail to make timely payments, the Provider may take necessary legal action to collect the outstanding balance, and I will be responsible for all costs and expenses incurred by the Provider, including reasonable attorney's fees and court costs.

6. I have received a copy of this signed agreement and had an opportunity to have this Agreement reviewed by my attorney

Effective date and cancellation: This Irrevocable Medical Lien Agreement shall come into full effect 72 hours after it has been signed by the Patient. The Patient may cancel this agreement within the 72-hour period by providing written notice to Tropical Medical Group, LLC. Such written notice must be received by the Provider before the 72-hour period has elapsed at which time any unpaid portion for medical services shall become immediately due. If no written notice of cancellation is received within the 72-hour period, this agreement shall remain in full force and effect. This Medical Lien Agreement is irrevocable and shall remain in effect until the Provider has received full payment for all medical services provided.

Patient / parent or legal guardian signature _____ **Date** _____

13 Prescription policy

Read the policy, then continue to the acknowledgments on the next page.

Patient name	Date of birth	Date

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from your treating physician, you are also accepting the responsibility to use the drug for yourself and only in the prescribed manner. Our responsibility is to prescribe medications in an appropriate dosage and amounts with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We accept NO excuse for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first correct course of action.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescription. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and the pharmacy phone number. 24-48 hours prior so that we will have sufficient time to confirm your medication and then to call your prescription into your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulations (DPR) or call the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

14 Acknowledgments

Prescription guidelines & advance-directive questions

Patient name _____ **Date of birth** _____

I agree to the following prescription guidelines

1. I will take any medications only as prescribed and I will not change the amount or the frequency without authorization from my physician.

2. I understand that due to the high potential for abuse and these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will be provided during regular office hours.

3. If another provider prescribes additional medications, I will notify my primary care physicians as soon as possible.

4. I will submit to random urine or blood tests if requested by my physician to assess my compliance.

5. If I do not follow these guidelines, I understand my treatment may be terminated.

Patient signature - prescription guidelines _____ **Date** _____

Health Care Power of Attorney / Living Will Declaration

Please indicate whether you have completed either document.

I have completed a Health Care Power of Attorney. ☐ Yes ☐ No

I have completed a Living Will Declaration. ☐ Yes ☐ No

Patient signature - advance-directive questions _____ **Date** _____

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:

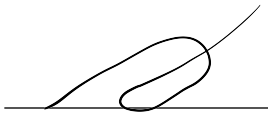
A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

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(14) and (15), 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***

Dr. Michael Slobaski, MD		_____
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.

OIR-B1-1571
Pub. 1/2004