FAMILY WELLNESS CENTER, INC.
ADVANCED THERAPY CENTER OF DELRAY BEACH
JOINT REJUVENATION CENTER

15127 Jog Road, Suite 210
DELRAY BEACH, FLORIDA 33446
561-498-1098 FAX: 561-495-2524

Hours of Operation

M-W-F: 9:00 – 5:00
T-Th: 9:00 – 1:00

AFTER BUSINESS HOURS:
LEAVE MESSAGE TO BE RETURNED NEXT BUSINESS DAY

Welcome to our Wellness Center

Our Mission Since 1997

To improve the lives of our patients by combining endless passion, commitment and proven science.

We offer state of the art Computerized Spinal Decompression, Chiropractic, Spinal Bracing, Massage Therapy, Physical Therapy and Stem Cell Therapy.
We also have an open door policy when it comes to questions about your treatment and your goals;
please do not hesitate to ask.

Yours through health,
David Livingston, D.C.

Advanced Therapy Center of Delray Beach

Family Wellness Centers, Inc.
Joint Rejuvenation Center
15127 Jog Road, Suite 210, Delray Beach, FL 33446

Personal Information

Last_____; First_____; MI_____; Sex_____

Street Address_____; City_____; State_____

Zip Code_____; Social Security Number _____

Home Phone (_____)-_____-_____; Office Phone (_____)-_____-_____; Student?____ Married? ____

Cell Phone; (_____)-_____-_____(IMPORTANT- CELL PHONE CARRIER?)_____

e-mail _____@_____

Date of Birth _____/_____/_____; Occupation_____

Driver License Number _____; State of Issue_____

Financial Information

Primary Insurance Co. _____Effective Date____/____/_____

Type (HMO. PPO, Auto, Worker Comp)_____; ID#_____

Insurance Co. #2 _____Eff.____/_____/_____; Type_____

Covered by VA or Black lung Benefits?_____; Who's Financially Resp. (Self/Wife's Insurance/other)_____; Lawyer Info (If Applicable) Name_____

Address_____; City_____; State_____

Phone Number (____)-_____-_____.

Claim Information

Auto Accident? _____ ; Work Related?_____; Other?_____; No Injury (skip section)_____

Claim Number_____; Date of Injury : ___/___/_____

Date of 1st visit for this injury ___/___/_____; Date of Similar Symptoms; ___/____/_____

Are you employed?_____; Company name _____

If injured, work related? _____; If Yes, authorization number _____

State where accident occurred_____ ; Hospitalized?____ ;

If applicable, dates you are unable to work ___/___/____ through ___/____/_____ or present.

Referral Information

Referring Physician Name _____ Type of Doctor ; _____

Other Referral Source Name_____

Phone Number of Referral Source (___)-____-_____; e-mail:_____@_____

Your Doctor's Street Address _____; City _____

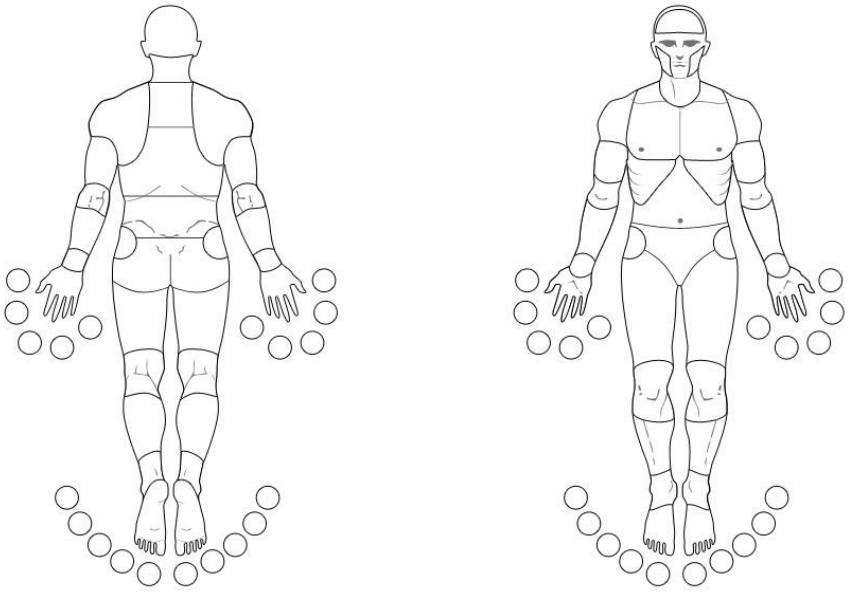
State _____; Zip Code _____

CURRENT COMPLAINTS

Patient's Name: _____ **Date:** _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint		
Location		☐Left ☐Right ☐Both ☐Center
Symptom Ratings		☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Excruciating)
Frequency		☐Infrequent < 25% ☐Occasional 25% to 50% ☐Frequent 50% to 75% ☐Constant > 75%
SymptomType		☐Weakness ☐Pain ☐Numbness ☐Tingling ☐Muscle Spasms ☐Burning
Severity		☐Mild ☐Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe
What makes it better?		☐Medication ☐Lying Down ☐Standing ☐Sitting ☐Stretching ☐Range of Motion ☐Nothing
What makes it worse?		☐Movements ☐ Bending ☐ Twisting ☐Weight Bearing ☐ Movements☐Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking☐Chewing ☐ Yawning ☐ Opening mouth ☐ Closing outh ☐Range of motion ☐ pushing/pulling ☐Lifting ☐Watching T.V. ☐Reading ☐Working ☐Driving Housework ☐Bright lights ☐ Loud Noises
Does pain radiate to any other locations?	Upper Body	☐Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐Face ☐ Right Jaw ☐ Left Jaw☐Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐Right Arm ☐ Left Arm ☐ Right ☐ Left forearm☐Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐Morning ☐ Afternoon ☐ Evening ☐ Night After Activities:☐ Light ☐ Moderate
Associated with		☐Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

Family Wellness Centers, Inc and Phoenix Therapy and Rehabilitation
15127 Jog Road, Suite 210
Delray Beach, FL 33446
561-498-1098

Activities of Daily Living

Instructions: Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

Communication
[__] I can communicate in a normal fashion.

[__] I can communicate, but it is sometimes difficult due to pain or another condition.

[__] I can communicate, but it is always difficult due to pain or another condition.

Normal Living - Sitting
[__] I am able to transfer from sit to stand independently in order to carry out my normal daily activities.

[__] Prior, I was able to go from sitting to standing with ease, however I now need occassional assistance to do so in order to carry out my normal daily activities.

[__] Prior, I could go from sitting to standing with occassional support, however now I require frequent assistance to transfer from sit to stand in order to carry out my normal daily activities.

[__] Prior, I required only frequent assistance, however now I am ALWAYS dependent on another person or assistance device to help me go from sitting to standing.

[__] Prior, I was more independent, however now I am always in my wheelchair, night and day.

Normal Living - Standing
[__] I am able to stand independently in order to carry out my normal daily activties.

[__] Prior, I was able to stand without assistance, however I now use a walker/cane to just stand.

[__] Prior, I could stand with walker/cane and perform MOST of my normal daily activities, however now I require someone's assistance.

[__] Prior, I required OCCASIONAL HELP In order to stand, now I am TOTALLY dependent on another person.

[__] Prior, I needed TOTAL help to stand, however now am unable to stand and am in wheelchair.

Normal Living - Lifting
[__] I am able to carry heavy objects independently.

[__] Prior, I was able to carry any objects, but now I am not able to carry heavy objects independently.

[__] Prior, I was able to carry any objects, but now I am only able to carry light objects.

[__] Prior, I was able to carry light objects, however now I cannot carry even light objects.

Ambulation
[__] I am able to ambulate independently without any difficulty or assistance.

[__] My prior level of function was better, but now I need to take frequent breaks when walking due to walking difficulty.

[__] My prior level of function was better, but now I am very cautious when ambulating due to frequent falls.

[__] My prior level of function was better, but now I am able to ambulate only with a walker/cane.

[__] My prior level of function was better, but now whether or not I use a walker/cane, I need someone's assistance when I walk/transfer.

[__] My prior level of function was better, but now I need maximum assistance for all of the above because I am in wheelchair.

Travel
[__] I am able to travel (locally or on a trip) without restrictions.

[__] Prior, I was able to travel almost anywhere, but now it now aggravates my symptoms and occasionally limits my travels.

[__] Prior, my symptoms only occasionally limited my travelling, but now I can manage only 2 hours of travel.

[__] Prior, I could travel for 2 hours, but now I can manage only 1 hour of travel because my symptoms are present and severe.

[__] Prior, I could travel for one hour, but now only short, urgent trips are possible due to limitations.

[__] Prior, short urgent trips were tolerated. Now I am restricted in travel so much due to my symptoms, other than emergencies of short distances (hospital, doctor visit).

Non Specialized Hand Activities
[__] I can grasp in a normal fashion.

[__] I had been able to utilize grip and had been aware of the object that I was holding, but now there is some minor pain and /or difficulty in doing so.

[__] I had been able to utilize grip and had been aware of the object that I was holding, but now there is moderate pain and /or difficulty in doing so.

[__] I had been able to utilize grip and had been aware of the object that I was holding, but now there is a lot of pain and /or difficulty in doing so.

[__] I had been able to utilize grip and had been aware of the object that I was holding, but now there is so much pain and /or difficulty that I am NOT able to do so.

[__] I had been able to utilize grip and had been aware of the object that I was holding, but now pain/weakness prevents grip strength, grasping and tactile discrimination completely.

Sleep
[__] I sleep well in a normal fashion.

[__] I sleep well at night, as long as I use sleeping pills.

[__] I fail to accomplish more than 6 hours of sleep.

[__] I fail to accomplish more than 4 hours of sleep.

[__] I fail to accomplish more than 2 hours of sleep.

[__] My symptoms prevent sleep.

Social & Recreational Activities
[__] I am enjoying a normal, active social life without restrictions.

[__] The presence of my symptoms affects only the more energetic activities of my social life (bowling, golfing, sports, etc.) that prior were easy.

[__] I participate in a normal social life, but my symptoms are increased during most activities that were easy before, but now am unable to perform.

[__] My symptoms restrict all of my social activities; therefore, I do not go as often I did prior.

[__] I am restricted to social activities at home due to my symptoms.

[__] Due to my symptoms, I do not participate in any social activities, home or out of home.

The Effects Of Medication

[__] I am able to tolerate my symptoms; therefore, I do not use any medication.

[__] I use medication and experience complete relief from my symptoms.

[__] I use medication and experience moderate relief from my symptoms

[__] Medication offers only very little relief from my symptoms.

[__] Medication fails to offer relief; therefore, I no longer take them.

Pain Intensity

[__] Prior, my symptoms were none, but now my symptoms are MINIMAL and tolerated but do not limit my physical performance.

[__] Prior, my symptoms were minimal but now are a little worse and cause some limitations on my physical performance.

[__] Prior, my symptoms were causing only some limitations on my daily function but now cause a significant limitation on my physical performance of daily activities.

[__] Prior, my symptoms caused significant amount of limitations, however now I am not able to perform any of my activities without assistance.

Pain Frequency

[__] I have INTERMITTENT symptoms occurring less than 25% of my wake time.

[__] I experience OCCASIONAL symptoms between 25% and 50% of my awake time.

[__] My symptoms are FREQUENT, and occur between 50% and 75% of my awake time.

[__] I have CONSTANT symptoms occurring between 75% and 100% of my awake time.

MEDICATION FLOWSHEET
Patient Name: Today's Date is:

I AM ALLERGIC TO:	MY REACTION IS:
1.	
2.	
3.	

MY MEDICATIONS ARE:	DOSAGE	FREQUENCY	THE REASON I TAKE IT IS:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Medical History Information

LIST SURGERIES AND DATES:

Primary Physician Name:

Current and past illness /Conditions:

☐ AIDS	☐ Cancer	☐ Cardiovascular Disease	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Stroke
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐ Joint Replacement
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐ Defibrillator
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐ Pregnant

Other:

Family History:

Anemia: Mother ☐ Father ☐ Sister ☐ Brother☐	Scoliosis: Mother ☐ Father ☐ Sister ☐ Brother☐
Arthritis: Mother ☐ Father ☐ Sister ☐ Brother☐	Thyroid Mother ☐ Father ☐ Sister ☐ Brother☐
Cancer: Mother ☐ Father ☐ Sister ☐ Brother☐	Emotional Difficulty: M ☐ F ☐ Sister ☐ Brother☐
Liver: Mother ☐ Father ☐ Sister ☐ Brother☐	Mult Sclerosis: M ☐ Father ☐ Sister ☐ Brother☐
Diabetes: Mother ☐ Father ☐ Sister ☐ Brother☐	Kidney: Mother ☐ Father ☐ Sister ☐ Brother☐
Heart: Mother ☐ Father ☐ Sister ☐ Brother☐	High Blood Pressure: M ☐ F ☐ Sis☐ Bro☐

Alcohol? ☐ No ☐ Yes Drinks per week?	Smoking History? ☐ No ☐ Yes Presently Smoking? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? Light / Moderate / Strenuous

Signature: _____ **Date:** _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CONSENT FOR TREATMENT

Welcome to our Wellness Center,

Although you may be here for Physical Therapy and/or Chiropractic, for the sake of paper-reduction this consent mentions both of these health disciplines.

I hereby request and consent to the performance of physical therapy, chiropractic adjustments, physiotherapies, nutritional support, other procedures, and possible diagnostic X-rays/MRI, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic and/or Physical Therapist named below and/or other licensed Doctors of Chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Physical Therapist and/or Doctor of Chiropractic named below or with other office or clinic personnel the nature and purpose of physical/occupational therapies, nutritional support, traction, chiropractic adjustments and other procedures. I understand that results are not guaranteed.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

Physical Therapy includes but is not limited to joint and spine mobilization/manipulation, dry needling, therapeutic exercise, neuromuscular techniques, muscle reeducation, hot/cold packs, and electrical muscle stimulation (e.g., cryotherapy, iontophoresis, electrotherapy) are modalities often used to expedite recovery in the orthopedic setting.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, nutritional support and physical therapies there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, drug interactions and sprains. I do not expect the doctor or therapist to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor or therapist to exercise judgment during the course of the procedure which the doctor or therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than the remedies listed above. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ **Date** _____

Witness Signature _____ **Date**_____

Doctor-David Livingston, D.C. Therapists-Miriam Klein, M.P.T., Ada Wetterer, PTA, Alfredo Silva, L.M.T.

Patient Care Insurance Agreement : In Consideration of your undertaking to care for me, I agree to the following:

1. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, or does not make payment within sixty days of your billing, I will become personally responsible for the amount. I will have thirty days to clear that account. If the account is not cleared in thirty days, I hereby authorize you to collect any outstanding amount on my credit card listed below.
2. Any insurance checks that may be forwarded to me for services received at Phoenix Therapy and Rehabilitation, Inc. and/or Family Wellness Center, Inc. and not paid for, will be endorsed by me and turned over to Phoenix Therapy and Rehabilitation, Inc. and/or Family Wellness Center, Inc. within five working days of receipt, for payment on my account. If I do not clear this portion of my account within five days, I hereby authorize you to collect the full amount of my account on the credit card listed below.
3. Any balance that is on my account will be paid for and cleared within 30 days of notification of amount. If a balance remains within thirty days, I hereby authorize you to collect that amount in full on the credit card listed below.

Name on Card_____
Credit Card Type MasterCard Visa
Card Number_____
Expiration Date____/____/_____
Signature_____
Witness Signature_____
Witness Name_____

Phoenix Therapy and Rehabilitation Services, Inc.
15127 Jog Road
Suite 210
Delray Beach, FL 33446

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the **Office Manager**. See 673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Checklist of Paperwork Provided

Patient Name_____ **Date:**_____

I have received and reviewed the following information:

Welcome Letter with Hours of Operation/ After Hours Access and How To Contact Us
Patient Information Form
Chief Complaints Form
Medical History Form
Pain and Disability Forms
Consent For Treatment
Patient Care Insurance Agreement and Assignment of Benefits Form
Authorization for Release of Information

Rights and Responsibilities **(Take this home)**
Home Safety Form **(Take this home)**
Complaint Procedure / Emergency Preparedness **(Take this home)**
Patient Privacy Notification **(Take this home)**
Supplier Standards **(Take this home)**
Patient Educational Materials attached to belt **(Take this home)**

I understand that I must contact Family Wellness Center, Inc. of any changes in my condition or if I am hospitalized

_____ _____
Customer/Caregiver Signature If Caregiver, Relationship to Patient

_____ _____
Witness Signature Date

This form kept in Patient Record

YOU MAY KEEP THE FOLLOWING DOCUMENTS AT HOME

HOME SAFETY INFORMATION

Here are some helpful guidelines to help you keep a careful eye on your home and maintain safe habits. Correct unsafe conditions before they cause an accident. Take responsibility and keep your home safe.

Medicines

- If children are in the home, store medications and poisons in childproof containers and out of reach.
- All medicines should be labeled clearly and left in original containers.
- Do not give or take medicines that were prescribed for other people.
- When taking or giving medicines, read the label and measure doses carefully. Know the side effects of the medicines you are taking.
- Throw away outdate medicines by pouring down a sink or flushing down the toilet.

Mobility items

When using mobility items to get around such as; canes, walkers, wheelchairs, or crutches you should use extra care to prevent slips and falls.

- Use extreme care to avoid using walkers, canes, or crutches on slippery or wet surfaces.
- Always put the wheelchairs or seated walkers in the lock position when standing up or before sitting down.
- Wear shoes when using these items and try to avoid obstacles in your path and soft and uneven surfaces.

Slips and Falls

Slip and falls are the most common and often the most serious accidents in the home. Here are some things you can do to prevent them in your home.

- Arrange furniture to avoid an obstacle course
- Install handrails on all stairs, showers, bathtubs and toilets.
- Keep stairs clear and well lit.
- Place rubber mats or grids in showers and bath tubs.
- Use bath benches or shower chairs if you have muscle weakness, shortness of breath, or dizziness.
- Wipe up all spilled water, oil, or grease immediately.
- Pick-up and keep surprises out from under foot, including electrical cords and throw rugs.
- Keep tubing under your control. Tubing may catch on furniture, doors, knobs, throw rugs, or other items on floor.
- Keep drawers and cabinets closed.
- Install good lighting to avoid groping in the dark.

Lifting

If it is too big, too heavy, or too awkward to move alone – GET HELP. Here are some things you can do to prevent low back pain or injury.

- Stand close to the load with your feet apart for good balance.
- Bend your knees and “straddle” the load.
- Keep your back as straight as possible while you lift and carry the load.
- Avoid twisting your body when carrying a load.
- Plan ahead – clear your way.

Electrical Accidents

Watch for early warning signs – e.g. overheating, a burning smell, sparks. Unplug the appliance and get it checked right away. Here are some things you can do to prevent electrical accidents.

- Keep cords and electrical appliances away from water.
- Do not plug cords under rugs, through doorways or near heaters. Check cords for damage before use.
- Extension cords must have a big enough wire for larger appliances.

- If you have a broken plug, outlet, or wire, get it fixed right away.
- Use a ground on 3-wire plugs to prevent shock in case of electrical “fault.”
- Do not overload outlets with too many plugs.
- Use three-prong adapters when necessary.

Smell Gas?

- Open windows and doors.
- Shut off appliance involved. You may be able to refer to the front of your telephone book for instructions regarding turning off the gas to your home.
- Don’t use matches, light candles or turn on electrical switches.
- Don’t use telephone – dialing may create electrical sparks.
- Call the Gas Company from a neighbor’s home.
- If your gas company offers free annual inspections, take advantage of them.

Fire

Pre-plan and practice your fire escape. Prepare a plan with at least two ways out of your home. If your fire exit is through a window, make sure it opens easily. If you are in an apartment, know where the exit stairs are located. Do not use the elevator in a fire emergency. You may notify the fire department ahead of time if you have a disability or special needs. Here are some steps to prevent fires:

- Install smoke detectors. They are your best early warning. Test frequently and change the battery every year.
- Throw away old newspapers, magazines and boxes.
- Empty wastebaskets and trashcans regularly.
- When there is oxygen in use, place a “No Smoking” sign in plain view of all persons entering the home **and do not permit anyone to smoke near the patient**
- Do not allow ashtrays or used matches to be tossed into wastebaskets unless you know they are out. Wet down first or dump into toilet.
- Have your chimney and fireplace checked frequently. Look for and repair cracks and loose mortar. Keep paper, wood, and rugs away from area where sparks could hit them.
- Be careful when using space heaters.
- Follow instructions when using heating pad to avoid serious burns.
- Check your furnace and pipes regularly. If nearby walls or ceilings feel hot, add insulation.
- Keep a fire extinguisher in your home and know how to use it.

If you have a fire or suspect fire

1. Take immediate action per plan – escape is your top priority.
2. Get help on the way – with no delay. CALL 9-1-1.
3. If your fire escape is cut-off, close the door and seal the cracks to hold back smoke. Signal help from the window.

*****IF YOU ARE DEPENDENT ON UTLITIES (gas, phone, electricity), REGISTER AS A HIGH PRIORITY CUSTOMER WITH EACH RIGHT AWAY*****

FAMILY WELLNESS CENTERS, INC.
Advanced Therapy Center of Delray Beach
15127 Jog Road, Suite 210, Delray Beach, FL 33446
RIGHTS AND RESPONSIBILITIES

As our customer, you are hereby provided this Bill of Rights. You have the right to be notified in writing of your rights and obligations before treatment has begun. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. We fulfill our obligation to protect and promote the rights of our patients, including the following:

Customer Rights

As the patient/caregiver, you have the RIGHT to:

- Be treated with dignity and respect.
- Confidentiality of patient records and information pertaining to a patient's care
- Be presented with information at admission in order to participate in and make decisions concerning your plan of care and treatment.
- Be notified in advance of the types of care, frequency of care, and the clinical specialty providing care and be notified in advance of any change in your plan of care and treatment.
- Be provided equipment and service in a timely manner.
- Receive an itemized explanation of charges.
- Express grievance without fear of reprisal or discrimination.
- Receive respect for the treatment of one's property.
- Be informed of potential reimbursement for services under Medicare, Medicaid or other third party insurers based on the patient's condition and insurance eligibility (to the best of the company's knowledge).
- Be notified of potential financial responsibility for products or services not fully reimbursed by Medicare, Medicaid or other third party insurers (to the best of the company's knowledge).
- Be notified within 30 working days of any changes in charges for which you may be liable.
- Be admitted for service only if the company can provide safe, professional care at the scope and level of intensity needed; if we are unable to provide services then we will provide alternative resources.
- Purchase inexpensive or routinely purchased durable medical equipment.
- Expect that we will honor the manufacturers warranty for equipment purchased from us.
- Receive essential information in a language or method of communication that you understand.
- Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected.
- To be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
- Access, request an amendment to, and receive an accounting of disclosures regarding your health information as permitted under applicable law.

Customer Responsibilities

As the patient/caregiver, you are RESPONSIBLE for;

- Notifying the company of change of address, phone number, or insurance status.
- Notifying the company when service or equipment is no longer needed.
- Notifying the company in a timely manner if extra equipment or services will be needed.
- Participating as in the plan of care/treatment.
- Notifying the company of any change in condition, physician orders, or physician.
- Notifying the company of an incident involving equipment.
- Meeting the financial obligations of your health care as promptly as possible.
- Providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertinent to your health.
- Your actions if you do not follow the plan of care/treatment.

Our Rights

As your provider of choice we have the right to:

- Terminate services to anyone who knowingly furnishes incorrect information to our company to secure durable medical equipment.
- To refuse services to anyone who during direct care is threatening, intoxicated by alcohol, drugs and/or chemical substances and could potentially endanger our staff and patients.

This page remains with the patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

Family Wellness Center, Inc. and Advanced Therapy Center of Delray Beach is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with this notice describing the following how your medical information is used and disclosed for your treatment, to obtain payment for treatment, administrative purposes and to evaluate the quality of care that you receive.

Uses and Disclosures: We use and disclose elements of your Protected Health Information (PHI) in the following ways:

- Treatment: including, but not limited to, inpatient, outpatient or psychiatric care.
- To your treating physician(s).
- Payment: including, but not limited to, asking you about your health care plan(s), or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts, either ourselves or through a collection agency or attorney.
- Health care operations: including, but not limited to, financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
- Disclosures when release is authorized by law: including, but not limited to, judicial settings and to health oversight regulatory agencies, law enforcement and correctional institutions.
- Uses or disclosures for specialized government functions: including, but not limited to, the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- In emergency situations or to avert serious health / safety situations.
- If you are a member of the armed forces, we may release medical information about you and your dependents as requested by military command authorities.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation claims.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organizations that handle organ and tissue donations.
- To public health organizations or federal organizations in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization
- We will notify you by e-mail or US Mail of any breaches of your PHI

You have the following rights concerning your protected health information (PHI):

Restrictions: To request restricted access to all or part of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request and you do not have the right to restrict disclosures required by law. If we do agree, we must honor the restrictions you request.

Confidential Communications: To receive correspondence of confidential information by alternate means or location such as phoning you at work rather than at home or mailing your health information to a different address. To do this, contact the organization's HIPAA Privacy and Security Officer. We will take reasonable actions to accommodate your request.

Access: To inspect or receive copies of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. In certain circumstances you may not have the right to access your records if the organization reasonably believes (or has reason to believe) that such access would cause harm. Examples include, but are not limited to, certain psychotherapy notes, information compiled in reasonable anticipation of or for use in civil, criminal or administrative actions or proceedings, or information obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Amendments / Corrections: To request changes be made to your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. We are not required to grant your request if we did not create the record or the record is accurate and complete. If we deny your request for amendment / correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we agree to the request, we will make the correction within 60 days and will send the corrected information to persons we know who got the wrong information, and others you specify.

Accounting: To receive an accounting of the disclosures by us of your PHI. To do this, contact the organization's HIPAA Privacy and Security Officer. By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. We are not required to give you a list of disclosures that occurred before April 14, 2003.

This Notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact: David Livingston, D.C.. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your protected health information (PHI). We must abide by the terms of this notice or any update of this notice.

As a patient of Family Wellness Center, Inc. and Advanced Therapy Center of Delray Beach, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting the information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

You may keep this page

COMPLAINT PROCEDURE

Family Wellness Center, Inc. and Advanced Therapy Center of Delray Beach provides a process for client's to lodge an oral, written, or telephone complaint about the products and services provided. We have a complaint resolution system for identifying, responding to, and resolving complaints in a timely manner. All written, oral, and Name of client or caregiver voicing the complaint
A summary of the complaint, including:

- Date received
- Name of the person receiving the complaint
- A summary of actions taken to resolve the complaint
- If an investigation is not conducted, the name of the person who made that decision, along with the reason for not conducting an investigation
- Signature of supervisor

All employees are trained in how to handle complaints. Copies of all complaints and investigations are kept on-file for at least three years. All complaints are summarized and presented to Executive Management quarterly.

If you have a complaint, please contact us at 561-498-1098.
Medicare Consumer Complaint Line: 1-800-Medicare
BOC: 410-581-6222
State of Florida : 1-800-435-7352

EMERGENCY PREPAREDNESS

Family Wellness Center, Inc. and Advanced Therapy Center of Delray Beach has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility, chemical spills in the community, hurricanes, tornadoes and community evacuations. Our primary goal is to continue to service your health care needs. It is your responsibility to contact us regarding any supplies you may require when there is a threat of disaster or inclement weather so that you have enough supplies to sustain you.

If a disaster occurs, follow instructions from the civil authorities in your area. We will utilize every resource available to continue to service you. However, there may be circumstances where we cannot meet your needs due to the scope of the disaster. In that case, you must utilize the resources of you local rescue or medical facility. We will work closely with authorities to ensure your safety.

This page remains with the patient