***Please check information and make changes if necessary***

# NEW PATIENT INFORMATION (1)

**Account #:**

Date: ______________

Patient: ______________________________ ______________________________ ________
Last Name First Name Middle Ini

SS#: ____________________________ Date of Birth: ________________ Age: ____ Sex: _______

Address: ______________________________ City: ____________________ State: ____ Zip: _________

Home #: _________________ Work #: ____________________ Cell # ____________________

Marital Status: __________________

Occupation: _____________________ Employed By ________________________________

Business Address: ________________________ City: ______________________ «EmployerAddrCity»

State: ___ Zip: _________

Date of Injury: ______________ Condition related to: ____work ____auto accident ____ other

If it applies: Who is your attorney: _________________________ Phone #: __________________

Who is the referring doctor: ______________________________________________________

## INSURANCE INFORMATION

Primary Insurance Company's Name:

Policy/Claim #__________________ Group # _________________ Insured: __self __spouse __other

Secondary Insurance Company's Name: ________________________________________

Policy/Claim #____________________ Group # ________________ Insured: __self __spouse __other

## INSURED'S INFORMATION (or responsible party if patient is a minor)

Insured's Name: ____________________________________________________________
Last First Middle Initial

SS#: _____________ Date of Birth: ___________ Home #: ____________ Work #: _____________

Address: ___________________________ City: ____________ State: _______ Zip: ___________

Occupation: _______________________ Employed by: ________________________________

Business Address: _______________________ City: ____________ State: ______ Zip: ________

*****Notice to all patients with insurance*****

**Your insurance is not a promise of payment. Our office cannot accept the responsibility of collecting your insurance claims or negotiate a settlement on a disputed claim. All fees incurred by the patient in this office are solely the responsibility of the patient (or parent if patient is a minor). As a service to you, we will complete and submit claim, regardless of any insurance claims. Full payment is due in 90 days unless prior arrangements are made. Any and all overpayments will be promptly returned.**

****Assignment of insurance benefits****

**I hereby instruct and direct my insurance company to pay Stuart B Krost, M.D., P.A., all benefits, if any, otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. I understand I am financially responsible for all charges incurred.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

X ____________________________________________________________

**Authorized Signature** Date

**Patient Name** ______________________________ Acct #: **(2)**

# Stuart B. Krost., M.D., P.A.

## PAIN MEDICATION AGREEMENT

If I choose to obtain Pain Medication (opiods), muscle relaxants or tranquilizers from Stuart B. Krost, M.D., Jarrod D Friedman I, «PatientFullName», knowingly and willingly do agree to enter into an agreement with my physician, Stuart B. Krost, M.D., with respect to the above listed medication.

1. I agree to obtain medication prescriptions from Stuart B. Krost, M.D. **only** and **no other source** while undergoing treatment.
2. I agree to take such medication as prescribed by my physician; certainly not any more than is prescribed.
3. I agree to the renewal policies as listed herein:
   -The physician will arrange a monthly follow-up appointment for medication renewal.
   -**The physician will not renew opiod medication on weekends or after office hours, 5pm Monday-Friday.**
4. I agree not to use illicit drugs or alcohol while under treatment.
5. I agree to offer a urine sample for drug screening on a random basis at the request of the treating physician.
6. Stuart B. Krost, M.D. has grounds to dismiss me from his care if I breech this agreement.
7. I understand that the goal of opiod medication is to improve my quality of life and improve my function and agree to discontinue use of this medication if it is causing harm to others or myself.
8. I understand the potential complications of using opiods and have agreed to this treatment.
9. Medication is for personal use only and for a medical condition being treated.

______________ X ______________________

**DATE** **PATIENT'S SIGNATURE**

______________ ______________________

**DATE** PHYSICIAN SIGNATURE

______________ ______________________

**DATE** WITNESS

**Patient Name** ______________________________________ **Date** ____________________ Acct #: **(3)**

# New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, **«PatientFullName»,** understand that as part of my health care, Stuart B. Krost, M.D., P.A., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Stuart B. Krost, M.D., P.A., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Stuart B. Krost, M.D., P.A., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Stuart B. Krost, M.D., P.A., change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

X________________________________

**Patient's Signature**

DATE: ________________

FOR OFFICE USE ONLY
[ ] Consent received by______________________________on______________________________.
[ ] Consent refused by patient and treatment refused as permitted.
[ ] Consent added to the patient's medical record on__________________________________.

**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.**

EVALUATION AND TREATMENT

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)* | X<br>**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.

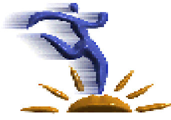
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own** hand):*

| **STUART B. KROST M.D**<br>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.



# Stuart B. Krost, M.D., P.A.

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□ 3615 Central Ave
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fax 561-296-2221

□ 9220 SW 72nd St
Suite #106
Kendal, Fl 33173
561-296-2220
fax 561-296-2221

□ Administration Office
3618 Lantana Rd, Ste201
Lake Worth, Fl 33462
561-296-2220
fax 561-296-2221

## HEALTH REPORTS & DOCTOR'S LIEN

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself.

I authorize you, my attorney, to pay directly to the above doctor; such sums as may be due him for any settlement, judgment or verdict as may be necessary. I understand that I am fully responsible for all medical bills and do hereby give a lien on my case to said doctor against any proceeds of settlement, judgment or verdict as the result of injuries for which I have been treated.

DATE: ____________________

PATIENT SIGNATURE: X______________________________________

**Patient Signature**

PATIENT NAME: __________________________

Thank you for your prompt attention to this request.

ATTY PH:
ATTY FAX:

ATTY NAME:
ADDRESS:
ADDRESS:
ADDRESS:

**Patient Name** ________________________________ **Appt Date:**________________ Acct #:



# Initial Evaluation

**NAME:** ____________________ **DATE:** ___________
**Age:** _____
**Right / Left ---**Handed
**SEX:** _______
**Date of onset:** ___________ **Onset of problem:** gradual / immediate

**Injury: Type:**
Work related, Motor vehicle accident, Other____________ Date: _____________
**Work related:** How did you injure yourself_______________________________
When did you stop working____________________________________________
Any prior work related injuries yes/no____________________________________
**Motor vehicle accident:** Struck from drivers side, passenger side, rear ended,
Any loss of consciousness yes / no
Were you able to get out of car on your own accord: yes / no,
Where you removed from the car: yes / no Did you go to E.R.: yes / no

**Prior treatment included:** Physical therapy: duration__________, last visit_______________
Injections: epidural: #____, trigger points: #____, joint: #___, nerve block:#____, facet block:#____
Other________________________________________________________________________
Surgery_______________________________________
Medication__________________________________________________________________
Chiropractic Manipulation with Dr __________________; how long__________; still going yes / no
Other________________________________________________________________________
**Prior treating physicians:**
_____________________________________________________________________________

**Are you seeing a Psychiatrist: Yes___ or No____; how long_________; Dr._______________**

**Present Complaint:** Neck/Back/R arm/ L arm/ R leg/ L leg/ Head/ Shoulder Blade
Location__________________ constant/intermittent,
Character of pain: aching, burning, stabbing, electric, throbbing
Pain radiates to extremity: yes/no left /right part of extremity___________
Numbness or tingling in extremity: yes/no location of numbness______________

Location__________________ constant/intermittent,
Character of pain: aching, burning, stabbing, electric, throbbing
Pain radiates to extremity: yes/no left /right part of extremity____________
Numbness or tingling in extremity: yes/no location of numbness_______________

Aggrevating factors: sit / stand / walk / bending / stress / other:_____________________________
Relieving factors: sit / stand / walk / lying down / ice / heat / other:_________________________
Pain with Coughing/ Sneezing / Bowel Movements yes / no
Accidents with Bowel / Bladder yes / no
Does pain interrupt your sleep: yes / no

**Present Pain Score** (0 thru 10, 0 is no pain and 10 being worst pain in the world)

**Worst**______ **Best**_______ **Present**_______

**Patient Name:** ____________________________ **Appt Date:** _____________ Acct #: _______________



# Initial Examination

**Past Medical History**

Diabetes, thyroid problem, high blood pressure, heart attack, angina, ulcers, reflux, blood clots, psychiatric disorder bleeding disorder, pregnant, cancer, asthma, visual problems, depression, anxiety, constipation,
History of drug abuse, alcoholism, HIV, Aids.
Other**:**______________________________________________________

**Prior accidents** (date and description of injury)___________________________________________________________
____________________________________________________________________________________________

**Past Surgical History** (date and type of surgery)
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**Medication:** (name and dose and frequency and Doctor's name)
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**Do you take : Aspirin y / n; Coumadin y / n; over the counter pain meds y / n ;**

**Allergies to medication: (name)**
____________________________________________________________________________________________

**Social History:**
Married / single / divorced / widowed
Children (ages)_______________________________________
Live in a single level home / 2 level home
Smoke cigarettes / Cigars: amount per day: _______________
Drink: Beer / Hard liquor: amount per day: ________________or Social drinker yes / no
Work status: Job title_______________________________full time / part time
If not working, when was last day of work and why ___________________________________________________
**How is your work performance affected?**__________________________________________________________
**How is your pain affected your household chores?**_________________________________________________
**How do your injury/pain affect your family life?**___________________________________________________
**How does your injury/pain affect your avocational activities?**__________________________________________
**How does your injury/pain affect your social activities?**_____________________________________________

**Family history:**
Father: alive / dead age:_________cause of death___________________________
Mother: alive / dead age:_________cause of death___________________________
Brother: alive / dead age:____/_____cause of death_____________/_____________
Sister: alive / dead age:____/_____cause of death_____________/_____________
Brother: alive / dead age:____/_____cause of death_____________/_____________
Sister: alive / dead age:____/_____cause of death_____________/_____________

Patient Name:________________________ **Appt Date:** __________ Acct #:



## REVIEW OF SYSTEMS:

**Circle the ones that apply for you:**

GENERAL: weight loss, weight gain, weakness or fever.
SKIN: rash, pruritus or lesions.
HEAD: trauma, headaches, tenderness or dizziness.
EYES: photophobia, diplopia or visual changes.
EARS: hearing impairment, tinnitus or pain.
NOSE: bleeding, obstruction or polyps.
THROAT: hoarseness or inflammation.
RESPIRATORY: shortness of breath, wheezing, coughing or colored sputum.
CARDIOVASCULAR: chest pain, difficulty breathing, rheumatic fever, murmurs, orthopnea, edema, palpitations or dizziness.
GI: changes of appetite, difficulty swallowing, nausea, emesis, diarrhea or constipation.
GU: urinary frequency, urgency or incontinence.
ENDOCRINE: polyphagia, polydipsia, polyuria or thyroid dysfunction.
HEMATOLOGIC: anemia, bleeding disorders or lymphedema.
NEUROPSYCHIATRIC: psychiatric illnesses, depression, anxiety, syncope, seizures, coordination deficits or emotional disturbances.

## FUNCTIONAL LIMITATIONS:

SITTING: Unlimited______, or limited to _______min or _______hrs

STANDING: Unlimited______, or limited to _______min or _______hrs

WALKING: Unlimited______, or limited to _______min or _______hrs

RIGHT ARM: Unlimited______, or limited to _______min or _______hrs

LEFT ARM: Unlimited______, or limited to _______min or _______hrs

RIGHT LEG: Unlimited______, or limited to _______min or _______hrs

LEFT LEG: Unlimited______, or limited to _______min or _______hrs

CONCENTRATION: Unlimited______, or limited to _______min or _______hrs

WORK CAPACITY: Prior to injury: Unlimited______, or limited to _______hrs; Did not work_______

Type of work:_______________________________________________

After injury: Unlimited______, or limited to _______hrs; Unable to work_______

Type of work:_______________________________________________