

# EMERGENCY M.A.T, LLC.

5471 W Waters Ave Ste 300, Tampa, FL, 33634

Ph: (813) 328-4120 Fax: (813) 328-4003

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

D.O.B: \_\_\_/\_\_\_/\_\_\_ Cell #: \_\_\_\_\_ SSN (Last 4): \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow Sex: ( ) M ( ) F ( ) O

Employment Status: ( ) Full Time ( ) Part Time ( ) Retired ( ) Unemployed ( ) W/C Pay

## Emergency Contact Info

Name: \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Worker's Comp Info

Case Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Type of Claim: ( ) CA1 ( ) CA2

Supervisor Email: \_\_\_\_\_

Attorney: \_\_\_\_\_ Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

Referred By: \_\_\_\_\_

INSURANCE MEDICAL RELEASE/ASSIGNMENT: I hereby authorize Emergence M.A.T,LLC to release any medical or other necessary information to my insurance carrier and/or attorney representing me in order to process my claims regarding my injury and treatment. I also understand that I am financially responsible for any charges not covered by workers' compensation case.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

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## Injury Questionnaire (For CA1 Injuries Only)

1. Where did the accident occur: \_\_\_\_\_  
\_\_\_\_\_

2. In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please describe how you felt:

**IMMEDIATELY** After the accident: \_\_\_\_\_  
\_\_\_\_\_

**LATER** that day: \_\_\_\_\_  
\_\_\_\_\_

The **NEXT** Day: \_\_\_\_\_  
\_\_\_\_\_

4. Where were you taken after the accident: \_\_\_\_\_  
\_\_\_\_\_

5. What are your **PRESENT** complaints and symptoms: \_\_\_\_\_  
\_\_\_\_\_

6. Have you been treated by another doctor since the accident? ( ) Yes ( ) No  
If yes, please list the doctor's names: \_\_\_\_\_  
\_\_\_\_\_

7. Do you notice any restrictions because of this injury? ( ) Yes ( ) No  
If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

8. Are you **CURRENTLY** taking any medication? ( ) Yes ( ) No  
If yes, please list your current medications you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Are you allergic to any medications? ( ) Yes ( ) No  
If yes, please list the medications you are allergic to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you **CURRENTLY** taking any OTC medications or herbal supplements? ( ) Yes ( ) No  
If yes, please list any OTC medications or herbal supplements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Family Medical History

Family	Check mark if Alive	Age of Death	Present Health or Cause of death
Mother			
Father			
Sister (s)			
Brother (s)			

Patient Medical History

Social History: Smoke Cigarettes ( ) Yes ( ) No If yes, how many per day: \_\_\_\_\_

Drink Alcohol ( ) Yes ( ) No If yes, how many per day: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Have you had any of the following? If so, please check all that apply.

**EYES:** ( ) Glasses ( ) Visual Loss ( ) Blurry Vision ( ) Glaucoma ( ) Cataracts

**E.N.T:** ( ) Hearing Loss ( ) Ringing in the ear ( ) Dizziness ( ) Nosebleed ( ) Hoarseness  
( ) Difficulty Swallowing

**CARDIOVASCULAR:** ( ) Chest Pain ( ) Irregular Heartbeat ( ) Heart Attack ( ) Heart Murmur  
( ) High Blood Pressure ( ) Rheumatic Fever ( ) Heart Disease

**RESPIRATORY:** ( ) Shortness of Breath ( ) Wheezing ( ) Coughing up Blood ( ) Asthma  
( ) Pneumonia

**GASTROINTESTINAL:** ( ) Loss of Appetit ( ) Vomiting ( ) Abdominal Pain ( ) Diarrhea  
( ) Constipation ( ) Ulcers ( ) Hemorrhoids ( ) Bloody Stool  
( ) Hepatitis ( ) Cirrhosis ( ) Irritable Bowel Syndrome

**MUSCULOSKELETAL:** ( ) Muscle or Joint Pain ( ) Joint Swelling ( ) Disc Hernia ( ) Arthritis  
( ) Atrophy ( ) Ligament Injury ( ) Muscle Weakness ( ) Stiffness  
( ) Limited Range of Motion

**INTEGUMENTARY:** ( ) Rash ( ) Itching ( ) Bruising ( ) Cancer ( ) Lesions ( ) Hair Loss  
( ) Ulcers ( ) Moles ( ) Scars ( ) Dry Skin ( ) Excessive Sweating  
( ) Open Wounds ( ) Changes in Skin Color

**NEUROLOGY:** ( ) Seizures ( ) Tremors ( ) Numbness ( ) Tingling ( ) Speech Problems  
( ) Loss of Consciousness ( ) Change in Hearing, Smell, Taste ( ) Weakness  
( ) Headaches ( ) Migraines ( ) Dizziness ( ) Fainting ( ) Memory Loss  
( ) Difficulty Walking ( ) Difficulty Concentrating ( ) Balance Problems

**PSYCHATRIC:** ( )Mood Changes ( ) Anxiety ( ) Depression ( ) Fear ( ) Sleep Disturbance  
( ) Panic Attacks ( ) Phobias ( ) Insomnia ( ) Memory Problems ( ) Stress  
( ) Difficulty Concentrating ( ) History of Counseling  
( ) History of Psychiatric Treatment

**ENDOCRINE:** ( ) Diabetes ( ) Thyroid Disease ( ) Excessive Thirst ( ) Excessive Urination  
( ) Excessive Sweating ( ) Sensitivity to Cold and Heat ( ) Weight Gain/Loss  
( ) Fatigue ( ) Hormone Therapy

**HEMATOLOGICAL/LYMPHATIC:**  Bleeding Problems  Easy Bruising  Fatigue  
 Swollen Lymph Nodes  Blood Clots  Anemia  
 Lymphoma  Leukemia  History of Transfusion  
 Frequent Infections

**IMMUNOLOGICAL/ALLERGIC:**  Seasonal Allergies  Food Allergies  Medication Allergies  
 Latex Allergies  Hay Fever  Frequent Infections  
 Lupus  HIV/AIDS  Autoimmune Disease  
 Immune Disease  Rheumatoid Arthritis

Previous Surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

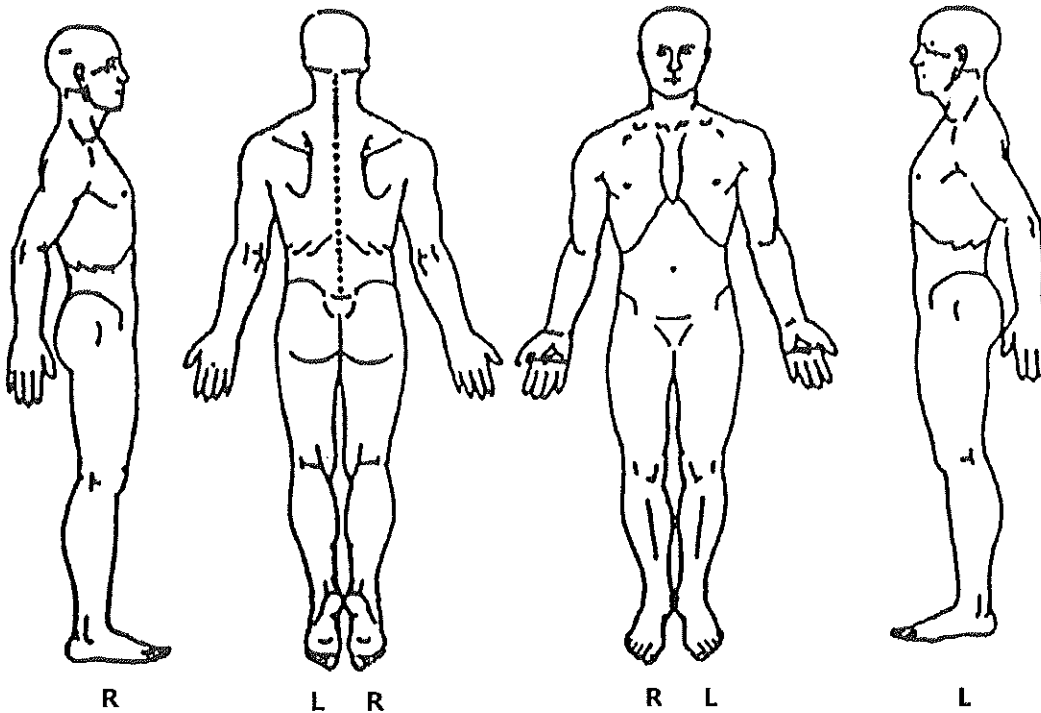
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Are you: ( ) Right Handed ( ) Left Handed

Please mark in the picture below where you are experiencing pain, discomfort, other injuries or symptoms from your accident; include numbness and/or tingling.



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## HIPPA ACKNOWLEDGMENT

I acknowledge that I have received the clinic's Notice of Privacy, which describes the ways in which the clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

**Disclosures to Family/Friends:** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Phone Number

Patient/Representative may revoke or modify this specific authorization, and that revocation or modification must be in writing.

**Communication about my Healthcare:** I agree the clinic may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

**Consent for Photographing or Other Recording for Security and/or Health Care Operations:** I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the clinic's health care operations purposes (e.g., quality improvement activities). I understand that the clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:** If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. The clinic does not charge for these services.

**Release of Information:** I hereby permit the clinic and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Consent for Treatment

I Agree for treatment to be provided to me by the physicians and therapist at Emergence – M.A.T, LLC. The treatment may include, but not be limited to:

Initial Evaluations, Follow-Ups, Hot/Cold Packs, EMS Attended/Unattended, Ultrasound, Mechanical Traction, Vibratory Massage, Hand Massage, Therapeutic Exercise, Therapeutic Activities, Myofascial Release, Muscular Re-Education, Paraffin Bath, Neuromuscular Re-Education, TENS Unit, Electrode Pads, Infrared Therapy, Kinesio Tape, Acupuncture, Iontophoresis

The Nature of the treatment, alternatives, and likelihood or success for treatment of my condition have been explained to me.

I consent to any treatment provided to me by the physician and staff who are licensed by the state of Florida. I understand that all reasonable efforts will be made to provide safe and appropriate care.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Control Substance Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management/anxiety/ADD/ and other medications that need monitoring for the safety of the patient. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals. **Please initials on the blank space.**

\_\_\_ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

\_\_\_ I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.

\_\_\_ I understand that if I break this agreement, my provider will stop prescribing these controlled medications.

\_\_\_ In this case, my provider will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

\_\_\_ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

\_\_\_ I will communicate fully and honestly with my provider about my health

\_\_\_ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse, or self-prescribe /medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

\_\_\_ I will not share my medication with anyone.

\_\_\_ I will not attempt to obtain any controlled medication, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

\_\_\_ I will safeguard my pain medications from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

\_\_\_ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.

\_\_\_\_ I agree to use \_\_\_\_\_ Pharmacy Located at \_\_\_\_\_ with the phone number of \_\_\_\_\_ for filling my prescriptions for all of my controlled medications.

\_\_\_\_ I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's board of pharmaceuticals, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care physician, and local emergency rooms. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

\_\_\_\_ I agree that I will submit to a urine test if required by my provider to determine my compliance with my program of my medications.

\_\_\_\_ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the prescription monitoring program website periodically throughout my treatment period.

\_\_\_\_ I agree that I will use my medication at rate no greater than the prescribed rate and that use of my medication at a greater rate will result in me being without medication for a period of time.

\_\_\_\_ I will bring unused pain medication to every office visit

\_\_\_\_ I agree to follow these guidelines that have been fully explained to me.

All my questions and concerns regarding treatment have been adequately addressed. A copy of this document has been given to me.

This agreement is entered into on this \_\_\_\_ day, the month of \_\_\_\_\_, 20\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Providers Name (Print): \_\_\_\_\_

