Patient Name:_____ Date of Birth:_____

TELL US ABOUT YOU (please print)

First_____ MI_____ Last_____
Address 1 _____
Address 2_____ CITY_____ ST_____ ZIP_____ COUNTRY_____
E-mail_____ ☐ Opt out of providing E-mail Address
Language Preference_____ SSN_____-_____-_____ DOB_____/_____/_____
Driver's License #_____ ST_____
Phone 1_____ CELL ☐ HOME BUSINESS ☐
Phone 2_____ CELL ☐ HOME BUSINESS ☐
Appointment Reminder Preferred Contact Method PHONE ☐ TEXT ☐ EMAIL ☐

Gender	Race	Status
M◯ F◯	☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ American/Alaskan Native ☐ ASIAN ☐ DECLINE	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

Ethnicity ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ DECLINE

Employment ☐ EMPLOYED ☐ DISABLED ☐ RETIRED ☐ PART-TIME Employer _____

Student Status ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT School _____

Emergency Contact Name_____ B3 Patient? ◯ YES ◯ NO
Relationship_____ Phone _____
Primary Care Physician_____ Phone_____
Did a Physician Refer you to us? ◯ YES ◯ NO Physician Name _____

How did you hear about us? _____

HEALTH INSURANCE (enter N/A if not applicable)

Insurance Company Name _____
Policy Type_____ Member Number _____
Group Number_____ Group Name _____
Effective from Date_____/_____/_____ Effective To Date_____/_____/_____

Secondary Insurance if applicable

Insurance Company Name_____
Policy Type_____ Member Number_____
Group Number_____ Group Name _____
Effective from Date_____/_____/_____ Effective To Date_____/_____/_____

Patient Name:_____ Date of Birth:_____

Information required by law. Complete only if the Primary Policy holder is NOT the patient.

Relationship to Primary Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ MOTHER ☐ FATHER ☐ _____

OTHER Primary Insured Name _____

Address 1 _____

Address 2_____ CITY_____ _____ ZIP_____

Phone 1 _____ CELL HOME BUSINESS _____ _____ _____ Gender M◯ F◯

DOB / / B3 Patient? YES◯ NO◯

AUTO ACCIDENT INSURANCE (enter N/A if not applicable)

Patient Auto Insurance Carrier_____ ID Number _____

Adjustor's Name_____ Claim Number _____

Adjustor's Phone #_____ Number of People in Vehicle_____

Name of Liable Insurance Company_____ Phone # _____

Attorney_____ Phone #_____ Date of Accident_____

WORK OR INJURY INSURANCE (enter N/A if not applicable)

Employer or Responsible Party_____ Claim Number _____

Contact Person_____ Phone Number _____

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Services? ◯YES ◯NO If YES, Name of Agency? _____

If YES, what type of Home Health Services are you receiving?_____ Last Date of Service _____

Are you currently a patient at a Skilled Nursing Facility? ◯YES ◯NO If YES, Name of facility? _____

If Medicare, have you received PT, OT, or Speech services since the first of the year? ◯YES ◯NO

- If YES, do you know if you have exceeded your Medicare Therapy Cap amount? ◯YES ◯NO
- Are you aware of any partial amount used since the first of the year? $_____.
- If YES, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Patient Name:_____ Date of Birth:_____

TELL US WHY YOU ARE HERE (please print)

What is the primary reason for your visit? _____

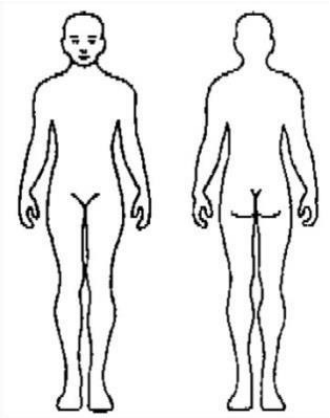
Where is the pain located? _____

Does the pain go anywhere from there _____

Does anything make the pain better? (e.g., ice, heat, medications, rest, etc.) _____

Does anything make the pain worse? (e.g., moving, standing, sitting, etc.) _____

How long have you had the pain? _____



Is your pain? ☐ OCCASIONAL ☐ INTERMITTENT ☐ FREQUENT ☐ CONSTANT

On a scale of 0-10, please rate your pain/symptom today?

None ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ = Worst Possible

Place the corresponding pain number on the picture where you have pain.

If Symptoms are intermittent, please describe when and how long? _____

_____

What is the nature of the symptoms?

☐Sharp ☐Dull Ache ☐Numb ☐Shooting ☐ Tingling ☐ Throbbing ☐ Squeezing

☐Deep Ache ☐Daily ☐Nightly ☐During Exercise ☐ Other _____

Cause of Pain? ☐Traumatic ☐Chronic ☐Post Surgical ☐Work Related ☐ Motor Vehicle ☐ Unknown

Are your symptoms changing? ☐Getting Better ☐Unchanged ☐ Getting Worse

Intensity of Symptoms ☐Mild ☐Moderate ☐Severe ☐Unbearable **Onset of Pain** ☐Sudden ☐Gradual

Have symptoms caused interference with work? ☐Yes ☐No If yes, how many days have you missed? _____

Have symptoms caused interference with your activities of daily living?

☐Not at all ☐A Little Bit ☐Moderate ☐Quite a bit ☐Extremely

Loss of Enjoyment ☐Sports ☐Hobbies ☐Work

Duties under duress ☐Vacuuming ☐Dusting ☐Gardening ☐Mopping ☐Cooking ☐Cleaning ☐Laundry ☐Preparing Dinner

Other _____

Have you been treated for this pain/condition before ◯Yes ◯No

If Yes, where?_____

What was your diagnosis? _____

Do you have any other associating symptoms? _____

Patient Name:_____ Date of Birth:_____

ARE THERE ANY OTHER AREAS OF CONCERN OR INTEREST (check all that apply)

☐ Weight Loss	☐ Personal Training	☐ New Primary Doctor	☐ Digestive Support
☐ Chronic Disease Management	☐ Anti-Aging	☐ Healthier Kids	☐ Stem Cell Therapy
☐ Depression / Mental Support	☐ Platelet Rich Plasma	☐ Osteoarthritis Treatments	☐ Physical Therapy
☐ Massage Therapy	☐ Chiropractic Care		

PAST MEDICAL HISTORY (please check all that apply)

DIAGNOSES

Denial of any significant medical history ☐	Hematologic disorder ☐	Anemia ☐	Coronary artery disease (heart attack) ☐	STD ☐
Headache ☐	Abdominal pain ☐	Anxiety ☐	Cancer ☐	Chest pain ☐
Cataract ☐	Glaucoma ☐	Hearing loss ☐	Edema ☐	Heart disease ☐
Congestive heart failure ☐	Hypertension ☐	DVT of lower extremity ☐	Emphysema ☐	Esophageal reflux ☐
Pneumonia ☐	Asthma ☐	Chronic obstructive pulmonary disease ☐	Diverticulitis of colon ☐	Irritable bowel syndrome ☐
Gastric ulcer ☐	Colitis ☐	Polyps of colon ☐	Hepatitis ☐	Chronic liver disease ☐
Hemorrhoids ☐	Cholelithiasis (gallstones) ☐	Cholecystitis (gall bladder disorder) ☐	Hyperlipidemia ☐	Obesity ☐
Chronic kidney disease ☐	Nephrolithiasis ☐	Urinary tract infection ☐	Polycystic ovarian syndrome ☐	Psoriasis ☐
Thyroid disorder ☐	Osteoporosis ☐	Diabetes mellitus ☐	Migraine ☐	TIA ☐
Arthritis ☐	Gout ☐	SLE ☐	Sleep apnea ☐	Tuberculosis ☐
CVA ☐	Dementia ☐	Depression ☐	Colon cancer ☐	Breast cancer ☐

Other _____

SURGICAL

Please notate the year of the surgery next to the type.

Tonsillectomy ☐	Heart surgery ☐	Varicose vein ligation ☐	Mastectomy ☐	Splenectomy ☐
Appendectomy ☐	Hemorrhoidectomy ☐	Cholecystectomy (gall bladder removal) ☐	Hernia repair ☐	Vasectomy ☐
Hysterectomy ☐	Cesarean section ☐	Prostatectomy ☐	Back surgery ☐	Hip surgery ☐
Knee surgery ☐	Fusions ☐	Laminectomy ☐	Hernia ☐	

Other _____

Patient Name:_____ Date of Birth:_____

RECENT EVENTS

Recent staphylococcal infection ☐ Recent streptococcal infection ☐ Recent upper respiratory infection ☐ Recurrent urinary tract infections ☐

REPORTED MEDICAL HISTORY

Recent hospitalizations? _____

Recent emergency room visits? _____

Recent psychiatric treatment? _____

PREVENTIVE HEALTH HISTORY

Check if you have had any of the following and provide date (month and year and/or results)

	Date	Results
Colonoscopy		
Cardiac Stress Test		
Mammogram		
Bone Density		
Pelvic and Pap		
Cholesterol Screening		
Prostate Antigen Test (PSA)		

Vaccines	Date
Tetanus (Td or Tdap)	
Pneumonia	
Zostavax (Shingles)	
Hepatitis B	
Influenza (Flu)	

SLEEP HISTORY

How many hours of sleep do you get on an average night? _____

What time do you go to sleep?_____ What time do you wake up? _____

Do you have difficulty falling asleep? YES ◯ NO ◯ Do you snore? YES ◯ NO ◯

How do you sleep? ☐ BACK ☐ FRONT ☐ SIDE

PSYCHOLOGY HISTORY

Have you ever had psychiatric or psychological counseling? YES ◯ NO ◯

Do you currently have emotional or psychological problems that concern you? YES ◯ NO ◯

Patient Name:_____ Date of Birth:_____

SOCIAL HISTORY (please circle all that apply)

BEHAVIORAL HISTORY

CAFFEINE USAGE YES NO If YES, how much per day? _____

TOBACCO USAGE YES NO (Please check all that apply)

Current every day smoker ☐ Current some day smoker ☐ Packs per day?_____ Previous history of smoking ☐ Never smoked ☐

ALCOHOL USAGE YES NO If YES, drinks per week? _____

Beer consumption ☐ Wine consumption ☐ Drinking in moderation -2 drinks/day or less ☐

Recent increases in alcohol consumption ☐ Recent decrease in alcohol consumption ☐ Stopped drinking alcohol ☐

Previous attempts to decrease alcohol consumption ☐ Recovering alcoholic ☐

DRUG USAGE YES NO If YES, Please check all that apply.

Barbiturates ☐ Marijuana ☐ Heroin ☐

Amphetamines ☐ Cocaine ☐

EXERCISE YES NO If YES, how often per week?_____How long per work out? _____

SEXUALLY ACTIVE YES NO

If yes, are your sexual partners ☐ Male ☐ Female ☐ Both

History of STI's (Sexually Transmitted Infections): YES NO

(HPV, Genital Warts, Chlamydia, Herpes, Gonorrhea, syphilis, other_____)

Have you ever been tested for HIV? YES NO

If Yes, what year? _____

If No, would you like to be tested? YES NO

Please check any of the following that apply to you:

Do you feel safe in your current relationship?	YES	NO
Do you feel afraid of a partner/spouse?	YES	NO
Have you ever, or are you currently suffering abuse (slapping, hitting, choking, yelling, threatened) in your relationship? If Yes: _____	YES	NO
Are your friends/family aware of any problems/abuse in your relationship?	YES	NO
Do you have an emergency escape plan and somewhere safe to go?	YES	NO

Patient Name:_____ Date of Birth:_____

PERSONAL HISTORY

WOMEN ONLY:

Vaginal discharge or infections? YES ○ NO ○
Painful intercourse or sexual activity? YES ○ NO ○
Abnormal vaginal bleeding? YES ○ NO ○
Do you douche vaginally? YES ○ NO ○
Breast lump, pain or nipple discharge? YES ○ NO ○
History of abnormal Pap Smear? YES ○ NO ○

MEN ONLY:

Discharge from penis? YES ○ NO ○
Lump or painful testicles? YES ○ NO ○
Problems with erection? YES ○ NO ○
Decreased sex drive/desire? YES ○ NO ○
Difficulty with urine stream? YES ○ NO ○

Date of first day of last menstrual period? _____
Age at first period? _____
Age at menopause? _____
Number of days of menstrual flow per cycle? _____
Flow (circle one) Mild Medium Heavy
Number of days between successive periods? _____
Number of pregnancies? _____
Number of children? _____

FAMILY HISTORY

Were you adopted? ○ YES ○ NO (If no, please complete the following table)

FAMILY MEMBER	Not in Good Health	Deceased	Diabetes mellitus	Cancer*	Chronic kidney disease	Heart disease	Systemic HTN	Obesity	Hyperlipidemia	Osteoporosis
FATHER										
MOTHER										
BROTHER(S)										
SISTER(S)										
DAUGHTER(S)										
SON(S)										

Type of Cancer * _____

Other_____

_____

_____

Patient Name:_____Date of Birth:_____

MEDICATIONS/SUPPLEMENTS CURRENTLY ON OR HAVE PREVIOUSLY USED

If you have a current list of medications, please allow the front desk staff to make a copy rather than fill out the list below.

Date Started	Medication Supplement Name	Dose Given	Frequency of Use (e.g., 2x per day)	Time (AM or PM)

Preferred Pharmacy name and phone/Location: _____

ALLERGIES

MEDICATION	REACTION

Do you use any medical equipment (e.g., cane, brace, wheelchair, etc.) _____

Intake Completed By_____**Date**_____/_____/_____

_____ **Date**_____/_____/_____

Patient, please sign here if the above information is complete and correct.

ATTENDANCE POLICY

Patient's Name:_____ Medical Record #: _____

Address:_____

City, State, Zip Code: _____

Our clinical provider's availability is very limited. Appointments are prioritized as part of your patient care and to enhance patient progress.

I understand if I call to cancel my appointment I will be asked to reschedule for another appointment the same week. This is considered a rescheduled appointment, not a cancelled appointment

If I am unable to reschedule for the same week, the appointment will be considered a cancelled appointment

If I cancel my appointment with < 24 hours notice, or if I no-show for my appointment, I may be charged a fee for the missed appointment

If I do not arrive within 5 minutes of my scheduled appointment I may receive a call reminding me of my current appointment.

If I am more than 15 minutes late for my appointment, I may be asked to wait to be seen at the next available time slot on the same day, or my appointment may be rescheduled for another day.

I understand that noncompliance with the care plan established by my clinical provider may result in denial of services by my insurance carrier and therefore I may be responsible for any and all charges incurred.

I also understand the fee associated with a cancelled and / or missed appointment is my responsibility and is not covered by my insurance, or any benefits under a personal injury case.

After 3 missed appointments I may be discharged from care at the discretion of the Center Manager.

I hereby agree to comply with the B3 Medical attendance policy as explained to me above

Patient's signature_____ Date_____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the Pain Institute of Tampa Bay PLC, Bain Complete Wellness LLC, and B3 Sports LLC, DBA B3 Medical, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name:_____ Date:_____

Patient Signature:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

1. I AUTHORIZE:

_____
(Name of receiving person/organization)

_____
(Street address)

_____
(City, State, Zip code)

_____
(Phone/Fax)

2. TO RELEASE RECORDS TO:

_____
(Name of receiving person/organization)

_____
(Street address)

_____
(City, State, Zip code)

_____
(Phone/Fax)

3. **INFORMATION TO BE RELEASED:** (check all applicable)

- ☐ Office Notes
- ☐ Labs
- ☐ EKG
- ☐ Imaging Reports / X-Ray CD
- ☐ Operative Reports
- ☐ ESI Reports & Evaluations
- ☐ Diagnostics & Evaluations
- ☐ All Available Records

INFORMATION TO BE RELEASED: Circle items and sign immediately below. By signing below, I am authorizing the office to release any and all information regarding:

Alcohol Drugs Mental Health HIV AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature:_____ Date _____

4. **RECORDS FROM THE TIME PERIOD:** / / THROUGH / /
5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other_____

6. This authorization will expire one year after the date signed. I understand that I may revoke this consent any time except to the extent that action has already been taken. I may refuse to sign this authorization and that it is strictly voluntary.
7. If the requestor or the receiver is not a health plan or a health care provider, the released information may no longer be protected by federal authorization.
8. The requestor may be provided with a copy of this authorization.
9. I may revoke this authorization at any time in writing and present my revocation B3 Medical, but if I do, it will not affect any action taken prior to receiving the revocation. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature_____ Date: _____

I also understand that in compliance with Florida Statute 395-3025, I will pay a fee of $1.00 per page for the first 25 pages and $0.25 thereafter. There will be a $25 fee for an X-ray CD. There will be no fees for medical records sent directly to another provider for ongoing care or follow-up treatment.

HEALTH CARE AUTHORIZATION FORM

Patient's Name_____Date of Birth:_____
THE PATIENT IDENTIFIED ABOVE AUTHORIZES Bain Complete Wellness LLC, Pain Institute of Tampa Bay PLC and B3 Sports LLC / DBA **B3 Medical (B3)** herein after known as **B3** TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS (Please initial each line)

_____I give permission to **B3** to use my address, phone number email address and clinical records to contact me with birthday cards, thank you cards, holiday related cards, newsletters, testimonials, list my name on the New Patient board, and contact me about treatment alternatives or other health related information.

_____I give **B3** permission to display any pictures that I give them of myself or my children on the picture wall in the clinics.

_____I give **B3** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak at any time in private; a private room will be provided for these conversations.

_____I give **B3** permission to combine any mailings with my spouse. I, also, give my spouse permission to call for and cancel my appointments.

_____I give my full consent to **B3** and/or its staff to use my unsolicited testimonial and photograph of me or my child, to whom I am the legal parent or custodian. I understand my testimonial and photography which I have freely provided will be used for promotional, technical or informational purposes as deemed in knowing the results I have obtained. I understand that this consent will not expire unless I provide written notice indicating my wishes to discontinue its use to the clinic.

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **B3**. The written notice must contain the following information: Your name, Social Security number, date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **B3** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **B3** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used / disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST*

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative Date

PREGNANCY WAIVER

I am certain that I am not pregnant at this date and time. However I hereby release B3 Medical of any responsibility.

_____ _____

Print Name Date of Birth

_____ Date_____/_____/_____

Signature

_____ Date_____/_____/_____

Witness

www.B3Medical.com

CHOOSE RIGHT NOW.®

HEALTH CARE PRIVACY NOTICE

B3 Medical (hereinafter known as B3) Shannon Chewning, Compliance Officer

Our staff is committed to maintaining the privacy of your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this Health Care Privacy Notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this Notice at anytime without additional notice to you except to publically post in our office and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request.

USE & DISCLOSURE OF PHI

Our office may use & disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list situations in which your PHI can be disclosed without your written authorization.

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgment from you is not practical until after the emergency situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations

Health Care Operations: For certain administrative, financial, legal, and quality control activities that are necessary to run its business and support the core functions of treatment and payment.
Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purposes.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other party(ies) to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions

Public Health Purposes: Your PHI may be disclosed to legally authorized public health authorities for the purpose of the prevention, control, investigations, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting

and spreading disease.

Research Purposes: Your PHI may be disclosed for research purposes either with your written permission or without any identifying characteristics.

Treatment: For the coordination or management of your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.

Worker's Compensation: State laws may permit disclosure of your PHI to comply with worker's compensation laws without your authorization and no minimum necessary standard is required.

Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to review and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by State Law

The Privacy Rule allows you the right to request that the disclosure of your PHI have restrictions on how your doctor will use your PHI regarding treatment, payment and health care operations. Your doctor may not agree to your restrictions, but would be bound by any restrictions you agree upon.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

You may revoke authorization, in writing, at any time, except in the event that the doctor has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed within 180 days of when you knew or should have known that the violation occurred. You may also contact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy law prohibits our office from taking any retaliatory actions against anyone who files a complaint.

I,_____,(patient's name) acknowledge that I have read and was given a copy of the Notice of Privacy Practices for the B3 and fully understand the same and have all my questions answered to my satisfaction.

_____

Patient's Signature Date

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name:_____ **Date:**_____ **Acct #:**_____

Bain Complete Wellness LLC, Pain Institute of Tampa Bay PLC, B3 Sports LLC / DBA B3 Medical herein after known as B3 appreciates the confidence you have shown in choosing us to provide for your medical and wellness needs. The services you have elected to participate in imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue treatment past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to B3 for providing medical and wellness services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to B3. I agree to pay B3 the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date**: _____

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health or billing information. Please take a few moments to complete this section.

I authorize B3 to disclose my health information that is directly related to my current treatment at B3 to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

(Such persons involved in your care may include: spouse, children, blood relatives, roommates, domestic partners, boyfriends/girlfriends, neighbors and colleagues.)

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the following individuals:

NAME	RELATIONSHIP

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date**: _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize B3 through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date**: _____

I further authorize B3 to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date**: _____