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 M F	Race ☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ American/Alaskan Native ☐ ASIAN ☐ DECLINE	Status ☐ 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_______________________ST___________ZIP__________

Phone 1_________________________CELL HOME BUSINESS DOB______/______/______ Gender M F

BCW 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.

B3 MEDICAL

Patient Name:______________________________Date of Birth:________________________

TELL US WHY YOU ARE HERE (please print)

What is the primary reason for your visit? ____

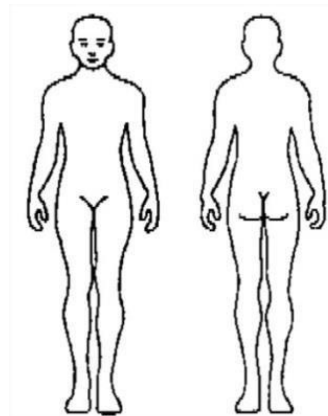
Where is the pain located? ____

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 = 0 1 2 3 4 5 6 7 8 9 10 = 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
☐ Chronic Disease Management
☐ Depression / Mental Support
☐ Massage Therapy
☐ Personal Training
☐ Anti-Aging
☐ Platelet Rich Plasma
☐ Chiropractic Care
☐ New Primary Doctor
☐ Healthier Kids
☐ Osteoarthritis Treatments
☐ Digestive Support
☐ Stem Cell Therapy
☐ Physical Therapy

PAST MEDICAL HISTORY (please circle 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 circle 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 circle 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

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? _______________

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

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____

____

____

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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.

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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

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Revised 01/2018

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

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**: ____________

CHOOSE RIGHT NOW.®

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