Name: _____ Date of Visit: _____
PLEASE PRINT If you need additional space write on another sheet & attach

CHIEF COMPLAINT: (What is the main problem for which you have an appointment this visit?)

_____
_____

HISTORY OF PRESENT ILLNESS: (When, where and how did the problem begin?) Be detailed.

_____
_____
_____
_____

Describe all prior spinal problems that you have had, even if resolved:

_____
_____
_____

MEDICATIONS: (Please list & include dosage. Include non-prescription medications and supplements)

Medication Name	Dosage	Medication Name	Dosage

MEDICATION ALLERGIES:

_____
_____

TESTS: (Tell us about New MRI, CT scans, or other tests you have had for your spinal problem and list the date performed.)

_____
_____
_____

PAST MEDICAL PROBLEMS & SURGERIES: (List your past experiences with other illnesses, operations, injuries and treatments)

_____
_____
_____
_____

Implants/surgical or other metal inside the body: Type_____ Location_____
If problems with anesthesia, please describe_____

FAMILY HISTORY :(Indicate family history of medical events of your parents/siblings including diseases which may be hereditary)

_____
_____
_____

SOCIAL HISTORY:

Your current work status_____ Occupation: _____

Alcohol Intake ❑Yes ❑No If yes, how much_____/Day _____Week
Tobacco use ❑Yes ❑No If yes, how much_____/Day _____Week
Caffeine: ❑Yes ❑No If yes, how much per day_____ Recreational drugs: ❑Yes ❑No
Do You See your Primary Care Physician for regular checkups ❑Yes ❑No

Exercise Routine: _____

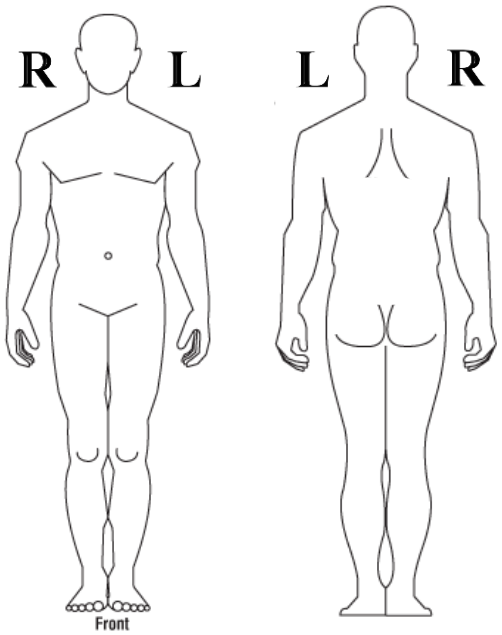
David Campbell MDPA

Initial Visit

NAME: _____ **DATE:** _____

Mark your pain on the body outline with the represented letter and mark how bad your pain is on a scale of 1-10.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
A	B	N	P	S	X



Mark Your Pain Estimate

Name: _____ Date: _____

Please bubble in the sheet below:

Review of Systems: (Do you have?)

General

Unexplained weight change	O Yes	O No
Fatigue	O Yes	O No
Loss of appetite	O Yes	O No
Fever or Chills	O Yes	O No

Skin

Rash	O Yes	O No
Itching	O Yes	O No
Lesions	O Yes	O No

HEENT

Headache	O Yes	O No
Vision change	O Yes	O No
Hearing change	O Yes	O No

Hematology

Easy bruising/bleeding	O Yes	O No

Lungs

Shortness of breath	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No

Cardiac

Chest pain	O Yes	O No
Palpitations	O Yes	O No
Murmur	O Yes	O No

GI

Heartburn	O Yes	O No
Reflux	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Bowel Problems	O Yes	O No

Musculoskeletal

Muscle pain	O Yes	O No
Joint pain	O Yes	O No
Swelling	O Yes	O No
Spasm	O Yes	O No
Stiffness	O Yes	O No
Loss of motion	O Yes	O No

GU

Urinary Problems	O Yes	O No
Sexual Problems	O Yes	O No

Neurologic

Weakness	O Yes	O No
Numbness	O Yes	O No

Endocrine

Hair/voice change	O Yes	O No

Psychiatric

Difficulty sleeping	O Yes	O No
Psychiatric Illness	O Yes	O No
Mood Swings	O Yes	O No

David Campbell MDPA

Last Name_____First Name _____MI_____

Address_____ City_____St _____Zip_____

Main # _____ Secondary # _____

*Email Address_____Date of Birth _____ Sex_____

*Race_____*Ethnicity_____*Language_____

*Social Security# _____-_____-_____ Drivers License#_____

Marital Status S _ D _ W_ Sep _ M_ Pharmacy Name: _____ Phone#_____

Pharmacy Address _____Employment Y____ N____

Employer _____Occupation _____

Emergency Contact

Name _____Relationship _____

Main Phone #_____Work Phone#_____

Referring Physician Name_____Phone #_____

Primary Care Physician_____Contact #_____

Primary Health Insurance Company_____

Policy Holder Name _____Relationship_____

Policy Holder's Date of Birth: _____SS#_____-_____-_____

Member ID #_____Group#_____

Secondary Ins. Co_____

Policy Holder Name_____ Relationship_____

Policy Holder Date of Birth_____ SS#_____-_____-_____

Member ID #_____Group #_____

----------*Auto Accidents Only*----------

Auto Insurance Company_____ Accident Date_____

Policy #_____Claim #_____

PIP Claims Adjustor_____Phone #_____

*** Required Per Meaningful Use**

David Campbell MDPA

NOTICE

ACKNOWLEDGMENT OF RECEIPT

HIPAA Privacy Policy

Patient Name: _____

I acknowledge that I have received a copy of the David Campbell, MD, PA, personal health information Privacy Policy.

X _____
Patient or Personal Representative Signature (circle one)

Date: _____

If personal representative signature appears above, please describe relationship to patient:

_____

_____

_____

David Campbell MDPA

PATIENT ACKNOWLEDGEMENT: OPIOID PAIN MEDICATIONS

_____ the patient, understand that I will only be prescribed OPIOID medication in the event that I have acute pain. Then, I will only be prescribed THREE days' worth of opioid medication or seven if medically necessary, as an exception. I acknowledge if my pain is not controlled adequately, the provider may refer me to a Pain Management specialist.

_____ _____

Patient Signature Date

David Campbell, M.D., P.A.
2055 Military Trail, Suite 303, Jupiter, FL 33458 Tel: 561-427-0860 Fax: 561-427-0870 2/2018

FINANCIAL RESPONSIBILITY AND AUTHORIZATION FORM

We are committed to providing you with the best possible care. To achieve these goals, we need your assistance, and your understanding of our payment policy. Payment is accepted in the form of cash, checks, MasterCard, Visa, American Express and Care Credit. Any exceptions to this or special arrangements must be made in advance with our financial counselor. We will be happy to provide you with a copy of your bill to file for reimbursement to your insurance carrier. You are being provided health care services through our practice with the full expectation that you will pay for these services. We will make every effort to bill appropriate health insurance carriers for these services for you, even when our group is not contracted. We will request authorization when required by your health insurance carrier for tests and treatments to assist you in receiving reimbursement from your insurance carrier. We suggest you consult with your plan for verification of your benefits and coverage. It is your responsibility to be familiar with the benefits and restrictions provided by your plan. We will gladly discuss your proposed treatment and answer questions relating to your insurance. Please be aware, however, that your insurance is a contract between you, your employer, and the insurance company. Not all services are a covered benefit in all contracts. If your insurance company denies any procedure as a "non-covered service" you will be responsible for these services. These may include medical conferences regarding your case, telephone consultations between you and the physician, and review of diagnostic studies such as CT, MRI and x-rays. Surgical assistant fees and durable medical equipment may not be covered. In certain situations, such as a scheduled surgery, you may be asked to pay a deposit based upon the procedure to be performed and the benefits verified by your insurance plan. This payment will also be expected in advance.

If you are seeking treatment due to the negligence of a third party and have a claim that is being made against the insurance company for the negligent party you understand that you are fully responsible for paying charges incurred with David Campbell, M.D., P.A. and will pay those amounts out of any insurance payment, settlement or award by a judge or jury. In the event that a recovery is made, you agree to direct your attorney to deduct the full amount of the bills owed to David Campbell, M.D., P.A. out of the proceeds within twenty (20) days of receiving those proceeds. You will receive a statement of outstanding balances incurred by you monthly.

Please be advised that returned checks are subject to an additional charge of $25.00. The original amount and the additional charge must be paid in cash, credit card or cashier's check. Failure to do so may result in your account being referred to a collection agency. Unpaid balances will be subject to a finance charge of 1.5%. Unpaid balances older than 90 days may be turned over to a collection agency. If this is necessary, you will be responsible for all fees and court costs incurred as a result.

You may not receive a bill from us while your insurance is processing your claims; however, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If circumstances cause you to need more time, we will make every effort to accommodate your particular needs as warranted. We encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

AUTOMOBILE ACCIDENT

I, the undersigned patient, hereby direct my Personal Injury Protection and/or Medical Payments Insurance Benefits Carrier to make payments for medical supplies and/or services rendered to me by David Campbell, M.D., P.A. as a result of the motor vehicle accident that occurred on _____.

I authorize and direct my PIP and/or M/P insurance carrier to make any and all check or drafts payable solely to David Campbell, M.D., P.A. and forward same to the practice at 2055 Military Trail, Suite 303, Jupiter, FL 33458. My signature below is an indication that the medical services being billed were, in fact, actually rendered, to the best of my knowledge and belief. Further, the medical provider attests that such medical supplies and/or services were medically necessary and that the bill submitted for same is the reasonable and customary charge for said medical supplies and/or services.

I, _____ hereby authorize _____ to make medical benefits
(Name of Insured/Patient) *(Name of Insurance Carrier)*
payments otherwise payable to me for services rendered by the practice but not to exceed the charges of those services, payable to and mailed directly to: David Campbell, M.D., P.A., 2055 Military Trail, Suite 303, Jupiter, FL 33458.

Furthermore, I hereby IRREVOCABLY ASSIGN to David Campbell, M.D., P.A. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by the practice. Further, a photocopy of this executed document shall be sufficient in law as any original.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I hereby authorize the practice to furnish the patients insurance company, CMS, attorney, or any representative thereof, with any and all information which may be requested regarding patient's past and present physical condition and treatment. I also authorize other health care providers to release information to the practice. I hereby authorize the physician in charge of the care of the patient to administer such medical care as may be deemed advisable in the diagnosis and treatment of this patient.

I authorize the patient's insurance company, attorney or CMS to pay direct to the group - David Campbell, M.D., P.A., any medical and/or surgical expenses payable under the terms of the contract. I also agree that any balance not covered will be paid by me and that photocopies of this form will be valid. I agree that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs.

I consent to the intervention by David Campbell, M.D., P.A. in any action, suit, or claim which may be filed by me and my attorney for injuries treated by David Campbell, M.D., P.A. In the event that a recovery is made, I agree and hereby direct my attorneys to agree to deduct the full amount of the bills I owe David Campbell, M.D., P.A. out of the proceeds within twenty (20) days of receiving those proceeds. I recognize my attorney(s) have the obligation to ensure that all the medical charges of David Campbell, M.D., P.A. are properly paid upon receipt of the funds from the insurance carrier or self -insured party. If the initial claim goes into an appeal process, the balance will not be deferred and must be paid in full at the time of the initial decision.

I agree to the terms and policy's stated and wish to be seen. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

Name of Patient (Please Print): _____

Signature: _____ Date Signed: _____