FINANCIAL POLICY

The purpose of this form allows Institute for Non-Surgical Orthopedics to treat you, and bill any insurance's you may have, share information with other health care offices/facilities, and collect on your account.

Regarding Insurance: Our office participates with Medicare and many managed care companies, including Auto and Workers Comp. As a courtesy we will bill all insurances. However, Co-payments, Co-insurances, Deductibles, and Non-covered services are the responsibility of the patient/guarantor and expected at the time of service. Any amounts not paid at time of service are subject to additional administrative fees as outlined below.

I authorize treatment by the providers of Non-Surgical Orthopedics. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Non-Surgical Orthopedics. If the correct insurance is not provided or the proper referral is not obtained, then patient acknowledges full responsibility for the bill.

I acknowledge that I received or read a copy of the Notice of Privacy Practices, which are posted in the waiting room.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable Attorney's Fee, Collection Agencies Fee, court costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

Special Needs: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise staff prior to receiving treatment. Co-pays are exempt as required by law and your insurance company. You are required to notify us if this is worker's comp or accident to avoid additional financial costs. If you are not covered by any insurance, let us know you are a self-pay and ask about our same day discounts.

Note our Fees for the following:

Returned check fee $30.00.
Any forms such as FMLA, Disability, etc. range from $15.00-$35.00 each.
There may be a $25.00 fee for any appointment not kept without 24-hour notice.
Co-pays, Coinsurance, Deductibles and Non-Covered services not paid at time of service will result in an additional $10.00 monthly service fee.
If a referral is required and not obtained, you will be responsible for payment for those services. Incorrect insurance information provided or changes in policies will be patient responsibility.

Patient/Guardian Signature/Date Relationship to Patient

JOEL D. STEIN, D.O., P.A.
4109 N. FEDERAL HWY
FORT LAUDERDALE FL 33308

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of the **Office Manager**. See 673.3111.

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **Please ask to view a copy of our charges. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

12/31/08

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the below from to the best of your ability.

Patient's Name: _____ Birth Date: _____ Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____ Quality: _____
(where is pain or problem) (example: normal vs. abnormal, color, etc)

Severity: _____ Duration: _____
(how severe is pain on scale 1-5, 5 being the most severe) (how long have you had pain/problem, when did it start?)

Timing: _____ Context: _____
(does pain/problem occur at a specific time) (where were you at the onset of pain/problem)

Associated Symptoms: _____ Modifying Factors: _____

_____ _____
(what other associated problems have you been having) (what makes the pain/problem better or worse)

Past Medical History:

Have you ever had the following: (Circle yes or no, leave blank if uncertain)

Measles	yes	no	Anemia	yes	no	Back Trouble	yes	no	Hepatitis	yes	no
Mumps	yes	no	Bladder Infection	yes	no	High blood pressure	yes	no	Ulcer	yes	no
Chicken pox	yes	no	Epilepsy	yes	no	Low blood pressure	yes	no	Kidney disease	yes	no
Whooping cough	yes	no	Migraines	yes	no	Hemorrhoids	yes	no	Thyroid disease	yes	no
Scarlet fever	yes	no	Tuberculosis	yes	no	Date of last chest x-ray _____			Bleeding	yes	no
Diptheria	yes	no	Diabetes	yes	no	Asthma	yes	no	Any other disease:		
Small pox	yes	no	Cancer	yes	no	Hives or Eczema	yes	no			
Pneumonia	yes	no	Polio	yes	no	Aids or HIV	yes	no	_____		
Rheumatic fever	yes	no	Glaucoma	yes	no	Infectious mono	yes	no			
Heart Disease	yes	no	Hernia	yes	no	Bronchitis	yes	no	_____		
Arthritis	yes	no	Blood/Plasma			Mitral valve prolapse	yes	no			
Venereal disease	yes	no	Transfusion	yes	no	Stroke	yes	no	_____		

Previous Hospitalizations/Surgeries/Serious Illness: When? Hospital, City, State

_____

_____

_____

ALLERGIES: _____

Medications: (Include non-prescription)

Medication: Dosage: How Taken:

_____

_____

_____

_____

Social History:

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of alcohol: Never_____ Rarely_____ Moderate_____ Daily_____
Use of tobacco: Never_____ Previous but quit/date_____ Current # of packs per day_____

Family Medical History: Age Disease If Deceased, Cause of death

Father: _____

Mother: _____

Sibling: _____

Sibling : _____

Children: _____

Spouse: _____

Review of Systems: Please indicate any personal history below:

--Constitutional Symptoms
Good general health lately yes no
Recent weight change yes no
Fever yes no
Fatigue yes no
Headaches yes no

--Eyes
Eye disease or injury yes no
Wear glasses or contact lenses yes no
Blurred or double vision yes no

--Ears/Nose/Mouth/Throat
Hearing loss or ringing yes no
Earaches or drainage yes no
Chronic sinus problems yes no
Nose bleeds yes no
Mouth sores yes no
Bleeding gums yes no
Bad breath or bad taste yes no
Sore throat or voice change yes no
Swollen glands in neck yes no

--Cardiovascular
Heart trouble yes no
Chest pain or angina pectoris yes no
Palpitation yes no
Shortness of breath when walking or lying flat yes no
Swelling of feet,ankles or hands yes no

--Respiratory
Chronic or frequent cough yes no
Spitting up blood yes no
Shortness of breath yes no
Wheezing yes no

--Genitourinary
Frequent urination yes no
Painful urination yes no
Blood in urine yes no
Change in force of strain when urinating yes no
Incontinence or dribbling yes no
Kidney Stones yes no
Sexual difficulty yes no
Male-Testicular pain yes no
Female-Pain with period yes no
Female-Irregular periods yes no
Female-Vaginal discharge yes no
Female-# of pregnancies _____
Female-# of miscarriages _____
Female-Date of last pap smear _____

--Musculoskeletal
Joint pain yes no
Joint stiffness or swelling yes no
Weakness of muscle/joint yes no
Back pain yes no
Cold extremities yes no
Difficulty walking yes no

--Integumentary (Skin/Breast)
Rash or itching yes no
Change in skin color yes no
Change in hair or nails yes no
Varicose veins yes no
Breast pain yes no
Breast lump yes no
Breast discharge yes no

--Neurological

--Psychiatric
Memory loss or confusion yes no
Nervousness yes no
Depression yes no
Insomnia yes no

--Endocrine
Glandular or hormone problem yes no
Excessive thirst or urination yes no
Heat or cold intolerance yes no
Skin becoming dryer yes no
Change in hat or glove size yes no

--Hematologic/Lymphatic
Slow to heal after cut yes no
bleeding or bruising tendency yes no
Anemia yes no
Phlebitis yes no
Past transfusion yes no
Enlarged glands yes no

--Date of last:
Mammgram:_____
Pap Smear:_____
PSA:_____
Colonoscopy:_____

Other Tests: _____

_____

_____

			Frequent or recurring headaches	yes	no
--Gastrointestinal			Light headed or dizzy	yes	no
Loss of appetite	yes	no	Convulsions or seizure	yes	no
Change in bowel movements	yes	no	Numbness or tingling		
Nausea or vomiting	yes	no	sensation	yes	no
Frequent diarrhea	yes	no	Tremors	yes	no
Painful bowel movement	yes	no	Paralysis	yes	no
Constipation	yes	no	Head injury	yes	no
Rectal bleeding or blood in stool	yes	no			
Abdominal pain	yes	no			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____

Signature of Patient, Parent, or Guardian Date

INSTITUTE FOR NON-SURGICAL ORTHOPEDICS

Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled substances.

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

I understand that if I break this agreement, my doctor will stop prescribing these pain controlling medications.

In this case, my doctor will taper off the medication's over a period of several days, as necessary, to avoid with-drawl symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication helps to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication's with anyone.

I will not attempt to obtain any controlled medication's, including opiod pain medication's, controlled stimulant's, or anti-anxiety medication's from any other doctor.

I will safeguard my medication's from loss or theft. I understand lost or stolen medication's will not be replaced.

I agree that refills for pain medication's will only be made at time of an office visit during regular business hours. No refills will be available during weekends or after normal business hours.

I agree to use _____ Pharmacy

located at _____

telephone number is _____, for filling prescriptions for all of my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any, city, state or federal law enforcement agency, including this state's Board of Pharmacy in the investigation of my possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respects to these authorizations.

I agree to submit to blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

I agree to use my medication's as directed and understand use greater than as directed may result in being without medication.

I agree to bring unused medications to each office visit.

I agree to follow these guidelines, which have been fully explained to me. I also acknowledge that all of my questions and concerns have been adequately answered and I have received a copy of this agreement.

_____ _____

Patient Signature/Date Physician Signature/Date

_____

Witness/Date

rev.4/2008

SWORN AFFIDAVIT FOR AUTO CLAIMS

STATE OF FLORIDA)
) SS.
COUNTY OF BROWARD)

BEFORE ME, the undersigned authority, personally appeared the below patient, who after being duly cautioned under oath, deposes and says:

1. My name is _____ (Patient's Name) and I make this affidavit upon personal knowledge. The below is true and correct.

2. I am a resident of the State of Florida, over the age of 18, and competent.

3. I am a patient of Institute for Non-Surgical Orthopedics.

4. I was injured in an automobile accident on _____ (Date).

5. The treatment I received from this provider was related to my car accident.

6. It was my express intention to assign my PIP benefits to Institute for Non-Surgical Orthopedics. I have signed an assignment of benefits from which is attached as Exhibit "1".

7. On the date of the accident described above my personal injury protection insurance company was _____ (Name of Insurance Carrier), which was in full force and effect.

FURTHER AFFIDAVIT SAYETH NAUGHT:

X_____
Patient's Signature

PERSONALLY APPEARED before me, the undersigned authority, duly licensed to administer oaths and take acknowledgements, the above patient, who, being, by me first duly sworn, deposes and says that he/she has read the foregoing affidavit, and the information contained herein is are true and correct to based on personal knowledge, information and belief.

_____ as identification.

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 20_____.

_____
Notary Public
My commission expires:

INSTITUTE FOR NON-SURGICAL ORTHOPEDICS

CENTER FOR OSTEOPATHIC MANIPULATIVE TREATMENTS (OMT)

4109 North Federal HighwayFort Lauderdale, Florida 33308

954-563-2707

FINANCIAL DISCLOSURE POLICY

AS A RESULT OG THE CHANGES TO THE 2003 "NO FAULT STATUTE", IT IS A THRID DEGREE FELONY FOR ANY PROVIDER TO AGREE TO WAIVE A DEDUCTIBLE OR REDUCE OR WAIVE A COPAY (IF APPLICABLE) AS A ROUTINE BUSINESS PRACTICE.

WE, THEREFORE, REQUIRE PAYMENT OF ANY BALANCES DUE AFTER ALL ATTEMPTS BY US (INCLUDING LITIGATION) TO COLLECT FROM THE NO FAULT COVERAGE WHOSE RIGHT TO COLLECT, YOU HAVE ASSIGNED TO US.

PLEASE SPEAK WITH OUR BILLING DEPARTMENT IF YOU HAVE ANY FURTHER QUESTIONS.

PATIENT SIGNATURE: DATE: