

## PATIENT INFORMATION

**Full Name:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Sex:**  Male  Female **Age:** \_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
**Social Security #:** \_\_\_\_\_ **Driver License #:** \_\_\_\_\_  
(HIPAA requires us to obtain a copy of your driver's license)  
**Occupation:** \_\_\_\_\_  Full-time  Part-time  Unemployed  Retired  
**Employer:** \_\_\_\_\_ **Length of Employment:** \_\_\_\_\_  
**Spouse's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Length of Employment:** \_\_\_\_\_  
**Children's names & DOBs:** \_\_\_\_\_  
**Whom may we thank for referring you?** \_\_\_\_\_

## CONTACT INFORMATION

**Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Text-Message Enabled?**  Yes  No  
**What is the best time and place to reach you?** \_\_\_\_\_ **I would like to receive appointment reminders via:** **TEXT** or **EMAIL**?  
**E-mail Address:** \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

## PATIENT CONDITION

**Area of Primary Complaint:** \_\_\_\_\_  
**When did your symptoms first appear?** \_\_\_\_\_  
**How did your symptoms start?** \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Not sure/no change

**Pain Rating: (mark circles)**

<b>Currently:</b> no pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	worst possible pain
<b>Average:</b> no pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	worst possible pain
<b>At Best :</b> no pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	worst possible pain
<b>At Worst:</b> no pain	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	worst possible pain

Do the symptoms radiate to any other body parts? \_\_\_\_\_

Described as?  Aching  Burning  Sharp  Stabbing  Throbbing  Other: \_\_\_\_\_

Frequency?  Infrequent (<25%)  Occasional (25-50%)  Frequent (50-75%)  Constant (>75%)

These Symptoms have interfered with my Activities of Daily Living?  Extremely  Quite a Bit  Moderately  A Little Bit  Not at All

Time of day at worst?  Morning  Afternoon  Evening  Night and/or **After Activity:**  Normal  Light  Moderate  Heavy

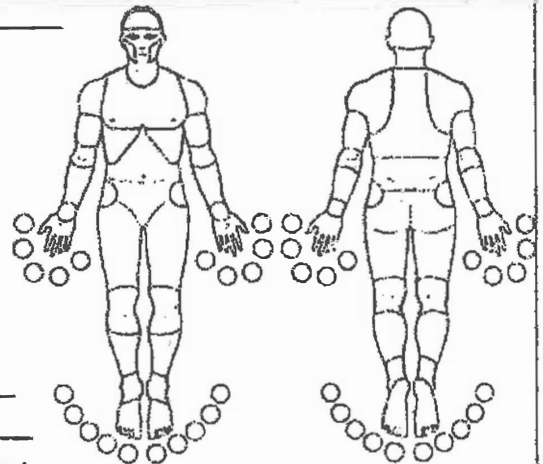
Does it interfere with your:  Work  Sleep  Daily Routine  Recreation  House Work  Driving  Other: \_\_\_\_\_

Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down  Other: \_\_\_\_\_

What makes it better?  Medication  Lying Down  Standing  Sitting  Stretching  Ice  Heat  Sleep  Nothing  Other: \_\_\_\_\_

What makes it worse?

<input type="checkbox"/> Movements	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Yawning	<input type="checkbox"/> Lifting	<input type="checkbox"/> Working
<input type="checkbox"/> Bending	<input type="checkbox"/> Sitting	<input type="checkbox"/> Opening Mouth	<input type="checkbox"/> Bright Lights	<input type="checkbox"/> Driving
<input type="checkbox"/> Twisting	<input type="checkbox"/> Standing	<input type="checkbox"/> Closing Mouth	<input type="checkbox"/> Loud Noises	<input type="checkbox"/> Housework
<input type="checkbox"/> Weight Bearing	<input type="checkbox"/> Walking	<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Watching TV	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Neck Flexion	<input type="checkbox"/> Chewing	<input type="checkbox"/> Pushing/Pulling	<input type="checkbox"/> Reading	<input type="checkbox"/> Other: _____



Comments: \_\_\_\_\_

## HEALTH HISTORY

**Present Illness/Conditions:** (mark all that apply)

- |                                    |  |  |   |  |                                  |
|------------------------------------|--|--|---|--|----------------------------------|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Disc Disease      | <input type="checkbox"/> Ulcer   |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Thyroid Trouble   | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> Prostate Trouble   | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> STDs    |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> AIDS    |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Disorder     | <input type="checkbox"/> Sinus Trouble      | <input type="checkbox"/> Bone Fracture     | <input type="checkbox"/> HIV/ARC |

Other: \_\_\_\_\_

**Family History of Illness/Conditions:** (mark all that apply)

- |                                    |  |  |   |  |                                  |
|------------------------------------|--|--|---|--|----------------------------------|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Disc Disease      | <input type="checkbox"/> Ulcer   |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Thyroid Trouble   | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> Prostate Trouble   | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> STDs    |
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| <input type="checkbox"/> Asthma    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Disorder     | <input type="checkbox"/> Sinus Trouble      | <input type="checkbox"/> Bone Fracture     | <input type="checkbox"/> HIV/ARC |

Other: \_\_\_\_\_

**Past Injuries/Surgeries:**

	Description	Date
Auto Accidents <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___
Slips/Falls <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___
Broken Bones <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___
Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	___/___/___

Previous Chiropractic Physician/Location: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Current Medical Physician/Location: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Other medical providers consulted for this condition: \_\_\_\_\_

Facility and Date of last: X-RAY \_\_\_\_\_

MRI \_\_\_\_\_

CT/BONE SCAN \_\_\_\_\_

Family History of back problems?  NO  YES, explain: \_\_\_\_\_

Check any treatments you have tried in treating this condition:  Ice  Dry Heat  Moist Heat  Stretching  Massage

Physical Therapy  Bed Rest  Medications  Other: \_\_\_\_\_

Results from treatments: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Sleeping Habits: Position:  Back  Stomach  Left Side  Right Side

Bed Type:  Conventional  Water  Tempurpedic  Air Pillows at head? ① ② ③ At Knees? ① ② ③ Body Pillow?  YES  NO

Activities you enjoy when healthy:  Stretch  Jog  Walk  Elliptical  Weights  Tennis  Bowl  Golf  Other: \_\_\_\_\_

## SOCIAL HISTORY

EXERCISE <input type="checkbox"/> YES <input type="checkbox"/> NO	WORK ACTIVITY	HABITS	
<input type="checkbox"/> Light	<input type="checkbox"/> Sitting <input type="checkbox"/> Computer Work	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week: _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Drinks/Day: _____
Hours/week: _____	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason: _____

**WOMEN:** Date of last menses: \_\_\_/\_\_\_/\_\_\_ Number of days in cycle: \_\_\_\_\_ Are you pregnant?  Yes  No  Unsure

All questions contained in this questionnaire are STRICTLY CONFIDENTIAL and will become part of your medical record at our office.



5 Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

6 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

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7 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

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8 What are you most concerned with regarding your problem?

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9 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

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10 What would be different/better without this problem? Please be specific

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11 What do you desire most to get from working with us?

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12 What would that mean to you?

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 **PRACTICE INFORMATION HERE**  
**Patient Quality Of Life Survey**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please take several minutes to answer these questions so we can help you get better.  
(Please circle as many that apply)*

- 1** How have you taken care of your health in the past?
  - a. Medications
  - b. Emergency Room
  - c. Routine Medical
  - d. Exercise
  - e. Nutrition/Diet
  - f. Holistic Care
  - g. Vitamins
  - h. Chiropractic
  - i. Other (please specify): \_\_\_\_\_
  
- 2** How did the previous method(s) work out for you?
  - a. Bad results
  - b. Some results
  - c. Great results
  - d. Nothing changed
  - e. Did not get worse
  - f. Did not work very long
  - g. Still trying
  - h. Confused
  
- 3** How have others been affected by your health condition?
  - a. No one is affected
  - b. Haven't noticed any problem
  - c. They tell me to do something
  - d. People avoid me
  
- 4** What are you afraid this might be (or beginning) to affect (or will affect)?
  - a. Job
  - b. Kids
  - c. Future ability
  - d. Marriage
  - e. Self-esteem
  - f. Sleep
  - g. Time
  - h. Finances
  - i. Freedom

## Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

### Let's get started.

Please circle any that apply to you prior to taking the quiz below:

#### Sub-Clinical symptoms including:

Headaches and migraines

#### Hormone imbalance including:

PMS

Emotional imbalance

#### Gastrointestinal issues including:

Abdominal bloating and cramps or painful gas

Irritable Bowel Syndrome

Ulcerative Colitis

Crohn's Disease and other intestinal disorders

#### Respiratory Conditions including:

Chronic sinusitis

Asthma

Allergies

#### Autoimmune Conditions including:

Diabetes Mellitus

Lupus

Rheumatoid Arthritis

Fibromyalgia

Chronic Fatigue

#### Developmental and social concerns including:

Austism

ADD/ADHD

#### Skin Conditions: (urticaria)

Eczema

Skin rashes

Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

### TYG Wellness Questionnaire

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3	Asthma, hayfever, or airborne allergies	0	1	2	3
Abdominal pain or bloating	0	1	2	3	Confusion, poor memory or mood swings	0	1	2	3
Mucous or blood in stool	0	1	2	3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3	History of antibiotic use	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3	Alcohol consumption makes you feel sick	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3	Ulcerative colitis or celiac's disease	0	1	2	3
Sinus or nasal congestion	0	1	2	3	Nausea	0	1	2	3
Chronic or frequent inflammations	0	1	2	3	Weight Trouble	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3					

YOUR TOTAL: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

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

## Informed Consent for Medical / Chiropractic/ Acupuncture/NAET/ Decompression/ Laser Treatment

Dear Patient,

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about your condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Every type of health care is associated with some risk of a potential problem. This includes Medical/Chiropractic/ Decompression Laser Therapy /Acupuncture/NAET care. We want you to be informed about potential problems associated with Medical /Chiropractic/ Decompression/ Laser /Acupuncture/NAET care before consenting to treatment. This is called informed consent.

### Chiropractic:

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function ( primarily the nervous system) and this relationship can affect the restoration and preservation of health.

Chiropractic adjustments/ joint mobilizations are performed by Chiropractors. It is the moving of bones to correct or reduce spinal and extremity joint subluxations with the doctor's hands or with the use of a mechanical device, following palpation and/or other examination procedures. A Vertebral Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and /or does not move properly causing interference and /or irritation to the nervous system. The primary goal of Chiropractic Care is the removal and/or reduction of the nerve interference caused by vertebral subluxation. A Chiropractic examination will be performed which may include spinal and physical examination , orthopedic and neurological testing, palpation, specialized instrumentation, x-rays and laboratory testing. Frequently with spinal or joint adjustments techniques create a "pop" or "click" sound/sensation in the area being treated, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. In addition some ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy, paraffin wax, cervical traction, mechanical traction, therapeutic exercises, vibrational –proprioceptive rehab, spinal and knee decompression, acupuncture/acupressure, laser, laser acupuncture may also be used. In this office, we use trained staff personal to assist the doctor(s) with portions of your consultation, examination, x-ray taking, physical therapy application, traction, decompression, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor under the direction of the primary doctor will treat you on that day.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment.

**Disc Herniation:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments/joint mobilizations, traction, decompression etc. This includes both in the neck and in the back. Yet, occasionally chiropractic treatment (adjustments/joint mobilizations, traction, spinal decompression/knee decompression etc.) may aggravate the problem and rarely surgery may become necessary for correction.

Rarely chiropractic adjustment/joint mobilizations may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments/joint mobilizations, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no statistics to quantify their probability.

**Rib Fractures:** The ribs are found only in the thoracic spine or the middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment/joint mobilization will crack a rib bone, and this is referred to as a fracture.

# Informed Consent for Medical / Chiropractic/ Acupuncture/NAET/Decompression/ Laser Treatment

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Print Patient Name: \_\_\_\_\_

This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust/manipulate all patients very carefully, and especially those who have osteoporosis noted on their x-rays. These problems occur so rarely that there are no statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, laser therapy ( class 3 cold laser ). We can recommend ice or heat or moist heat therapy for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no statistics to quantify their probability. Furthermore physiotherapy may include the proceeding as well as a allergic reaction to gels or lotions in some cases.

Soreness: It is common for chiropractic adjustments/joint mobilizations, traction, massage therapy, exercise, etc. to result in a temporary increase in the soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please tell your doctor about it.

Acupuncture: If using dry needling technique the following risks can occur: infection at site of insertion of needle, bruising, itching, redness, swelling, allergic response to needle.

NAET: Sweating when holding the substance, itching, fatigue after treatment, muscle weakness after treatment.

Probability of risks occurring: There may be other problems or complications that might arise from Chiropractic/Medical/Acupuncture/NAET other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and / or explain them all in advance of treatment. The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered 'rare'.

Other treatment options, which could be considered, may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult. The same consequences can occur with patients suffering from allergies, chronic conditions and specific medical problems not listed here.

Chiropractic/ Medical/ Acupuncture/ NAET is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease, or condition as a result of treatment in this center. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

1. I, \_\_\_\_\_, authorize the performance upon myself of the following procedure(s): Examination/ X-rays( gowned if needed) Ultrasound, sinusoidal current, interferential currents, traction, decompression, hydrocollator, electrical muscle stimulation, laser therapy, ice therapy, acupuncture, N.A.E.T, and chiropractic manipulative/joint mobilization techniques to be performed by or under the direction of the Doctors and staff of Integrated Medical Center, Inc. d.b.a./Quantum Medical & Wellness Center
2. I also consent to the performance of other diagnostic and / or therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the doctors, associates and / or assistants, may consider necessary or advisable in the course of my health care or treatment.



3. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the doctors, their associates or assistants.
4. I have read the explanation above of medical / chiropractic/ acupuncture / NAET/decompression treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I, \_\_\_\_\_ of my own free will choose to become a patient of Drs./Therapists Popkin/Grundstein/Desir/Debrosse. I understand that some of the techniques and products used in this clinic are neither FDA (Food and Drug Association) approved or considered a "main stream" traditional medicine.

Drs. Popkin/Grundstein//Desir/Debrosse can not guarantee the results of these treatments or products.

I am aware that I am free to seek other medical opinions or other care at any time. I am also aware that Drs. Popkin/Grundstein/ Desir/ Debrosse meet the requirements by Florida law.

I hereby exercise my freedom of choice in Medicine/Chiropractic/ NAET/Acupuncture/ Decompression Therapy/ Massage Therapy/ Manual Therapy/ Laser Therapy to follow Drs. Popkin/Grundstein/Desir/Debrosse recommendations or not as I choose.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grandstein M.D, LLC.**

**Hipaa Consent Form**

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

In connection with the medical services that I am receiving from **Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grandstein M.D, LLC.** and its medical staff, I hereby authorize **Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grandstein M.D, LLC.** the above-named practitioner(s), and their respective agents to disclose any information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to:

- A. any third party payor covering the medical services of the patients
- B. other health care professionals and institutions involved in the delivery of health care to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services, and payment for such services;
- E. Pharmacies;
- F. As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my practitioner or by a photographer approved by my physician.
3. The photographs shall be used for medical records and, if in the opinion of my practitioner, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.
4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

- Telephone messages on an answering machine
- Messages to the following family members or friends:
- E-mail to the following address: \_\_\_\_\_

5. I also consent to the release of Protected Health Information to the following individual(s):

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

\_\_\_\_\_

This consent is valid from the date executed until revoked in writing by the patient.

Signed: \_\_\_\_\_

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

Witness: \_\_\_\_\_

In accordance with the Health Insurance Portability and Accountability Act, patients of **Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grundstein M.D. LLC.**

are entitled to and afforded the rights to privacy regarding their health-related health-related information as set forth under applicable law. The Practice will strive to ensure that patient information is used only for purposes authorized by the patient and as otherwise required by law. Upon request, we can provide you with a complete copy of our Privacy Policies.

Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice

Moreover, patients have the right\*to be informed of any breach of their unprotected PHI; \*to have marketing communications made to them only if authorized by the patient;

\*to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim. \*to contact the Practice HIPAA Compliance Officer, Dr. Popkin at 954-370-1900

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

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

### **Informed Consent Regarding Nutritional and Herbal Supplements**

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure mitigation, treatment or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patients' diet and to supply nutrition to support the physiological and biochemical processes of the human body. Although these products may also be suggested with specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

### **Sales of Nutritional Supplements at Quantum Wellness Center**

*You are under no obligation to purchase nutritional supplements at our clinic.*

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product, (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, \_\_\_\_\_, have read and understand the above statement.

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

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

Integrated Medical Centers, Inc., d/b/a Quantum Wellness Center  
1261 S. Pine Island Rd, Plantation, FL 33324 (954) 370-1900

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM  
AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY**

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I \_\_\_\_\_ hereby assign, transfer and convey to **INTEGRATED MEDICAL CENTERS, INC., d/b/a QUANTUM WELLNESS CENTER** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:

(1) Request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,

(2) To endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby 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.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

**THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.**

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Thank you for choosing Integrated Medical Center, d.b.a. Quantum Medical & Wellness Center as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

#### **CO-PAYS**

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no postdated checks will be accepted.

#### **INSURANCE CLAIMS**

In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If you do not turn over the payment your insurance carrier made, collection efforts will start. Collection process is to notify your carrier you have kept the checks and to issue a 1099 to you for fax reporting purposes. The IRS will be notified so they know you will be reporting additional income.

**IF YOUR INSURANCE PLAN IS ONE WITH WHICH WE ARE NOT A PARTICIPATING PROVIDER, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL. HOWEVER, AS A COURTESY, WE WILL FILE YOUR INITIAL INSURANCE CLAIM AND IF NOT PAID WITHIN 30 DAYS, YOU WILL BE RESPONSIBLE.**

#### **REFERRALS AND PRE-AUTHORIZATIONS**

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

## **SELF-PAY ACCOUNTS**

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

## **WORKERS' COMPENSATION**

It is the patients' responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

## **MISSED APPOINTMENTS**

We require a 24-hour notice of appointment cancellation.

## **MINORS**

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

## **OUTSTANDING BALANCE POLICY**

Any balance not collected at time of period will be due in 30 days. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Credit Card Payments- if paying with a credit card there is a 3.49% processing fee on Visa, Mastercard and Discover. If using Amex there is a 6% processing fee.

INTEGRATED MEDICAL CENTERS INC. dba/ QUANTUM MEDICAL & WELLNESS  
CENTER

Print Patient Name: \_\_\_\_\_

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

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