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

E-mail Address: _____ reminders via: **TEXT** or **EMAIL**?

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home: _____ Work: _____ Ext: _____ Cell: _____

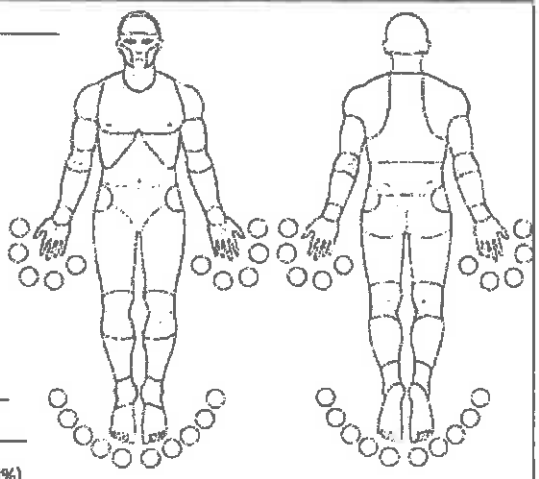
PATIENT CONDITION

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)

Currently:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
Average:	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Best :	no pain	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ worst possible pain
At Worst:	no pain	⓪	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?

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

Comments:

HEALTH HISTORY

Present Illness/Conditions: (mark all that apply)

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

Other:

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

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

Other:

Past Injuries/Surgeries: **Description** **Date**

Auto Accidents ☐Yes ☐No _____ ____/____/____

Slips/Falls ☐Yes ☐No _____ ____/____/____

Broken Bones ☐Yes ☐No _____ ____/____/____

Surgeries ☐Yes ☐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? ⓪ ① ② ③ At Knees? ⓪ ① ② ③ Body Pillow? ☐YES ☐NO

Activities you enjoy when healthy: ☐ Stretch ☐ Jog ☐ Walk ☐ Elliptical ☐ Weights ☐ Tennis ☐ Bowl ☐ Golf ☐ Other: _____

SOCIAL HISTORY

EXERCISE ☐YES ☐NO	WORK ACTIVITY	HABITS	
☐ Light	☐ Sitting ☐ Computer Work	☐ Smoking	Packs/Day: _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week: _____
☐ Heavy	☐ Light Labor	☐ Coffee/Caffeine Drinks	Drinks/Day: _____
Hours/week: _____	☐ Heavy Labor	☐ 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.

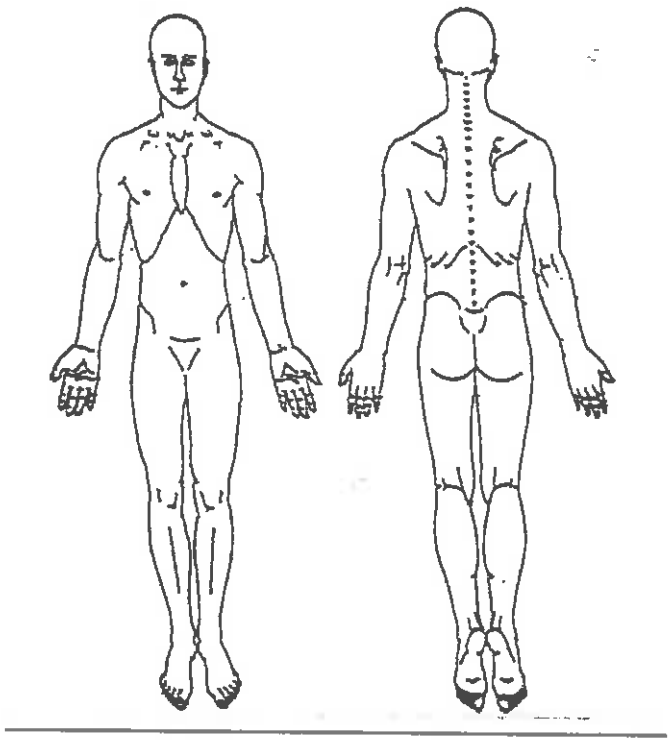
Pain Diagram and Pain Rating

Name: _____ **Date:** _/_____/_____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	**= 000000**	**Stabbing**	**= //////**
Burning	**= xxxxxx**	**Deep Ache**	**= zzzzzz**



Please rate your current level of pain on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Personal Injury Questionnaire

Name: _____ Birth Date: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Details of the Accident (Please circle Appropriate Responses)

1. Date of Accident: _____ Time of day: _____ AM/PM
2. Road Conditions: Dry Wet Icy Grave Road Pavement Other
3. Were you: Driver Passenger Front Seat Back Seat
4. What direction were you headed? North South East West
5. Were you stuck from: Front Rear Left Side Right Side
6. Were you aware of the impending collision? YES NO
7. Did you lose consciousness (Black Out)? YES NO
8. Were you wearing a seatbelt at the time? YES NO
   What type of seatbelt? Lap belt Shoulder Belt Shoulder/Lap Belt
9. Describe the position of your head rest or back seat relative to the position of your ears at impact? Above Below #:_____
10. List the year, make and model of vehicle you were in:
    Year: _____ Make: _____ Model: _____
11. Was the vehicle you were in at the time of impact: Stopped / Moving
    If stopped, was driver's foot on the brake? YES NO
    If moving, estimate approximate speed of the vehicle _____
12. In your own words, please describe the accident:

13. Were the police notified of the accident? YES NO
14. Please describe what happened to you following the accident? (I.e. transported to the hospital by ambulance, taken to hospital by friend, etc.):

15. Please describe bleeding cuts or bruises received as a result of your accident:

16. Please describe if any of your body parts truck any part of the vehicle. For example, head hit windshield, chest hit streeling wheel, etc.):

17. Was your head pointed straight ahead at the time of the accident?
    YES OR NO. . . If "NO" which direction was it turned? _____
18. Was your torso pointed straight ahead at the time of the accident?
    YES OR NO. . . If "NO" which direction was it turned? _____
19. Which of following vehicle parts broke during the accident:
    Windshield RT/LT Window Front/Back Seat Steering Wheel
20. What was the cost of damage to the vehicle you were in? _____

The following questions pertain to the other vehicle involved in the accident:

1. What was the year, make and model of the other vehicle?
   Year: _____ Make: _____ Model: _____
2. Was the other vehicle moving at the time of the collisions? YES NO

If "yes", what was the vehicle's approximate speed? _____

3. If the other vehicle was moving at the time of the time of the accident, was it:
   Slowing down Gaining Speed Traveling at a steady speed

Health History Questions:

1. What are your complaints or symptoms (Since the accident):

2. Did you have any physical complaints BEFORE THE ACCIDENT?
   Yes NO
   If yes, please describe in detail:

3. Have you received treatment for the injury since the accident?
   If Yes, Please list Doctors name, address & describe service you received:

4. If you been in previous auto accidents or have received treatment for any other significant injuries other than described above, please list the type of accident or approximate date below:

To the best of my knowledge, the information I provided above is correct & true.

Patients Signature: _____ Date: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable ***(Signature by his/ her own hand):***

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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 knowledgably 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 –propreceptive 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 heath 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.

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 I 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 Grundstein M.D. LLC.

Hippa Consent Form

Patient: _____

In connection with the medical services that I am receiving from (**Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grundstein M.D. LLC.** and its medical staff, I hereby authorize (**Integrated Medical Centers Inc./DBA/ Quantum Medical & Wellness Center, Michele Grundstein 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: _____

QUANTUM MEDICAL & WELLNESS CENTER

HIPAA OMNIBUS RULE

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Print Patient Name: _____

I acknowledge that I have been provided a copy of the currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

DATE: _____

_____

Signature of Patient or Personal Representative

_____

Signature of Witness / Office Representative

You may refuse to sign the acknowledgment & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I **declined** the Notice of Privacy Practices provided:

DATE: _____

_____

Signature of Patient or Personal Representative

_____

Signature of Witness / Office Representative

****

Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: __ Individual refused to sign ___ Communication barrier ____ Emergency situation occurred with patient___ other (explain): _____

_____

_____

Signature of Office Representative

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 CENTER INC. d.b.a. QUANTUM MEDICAL & WELLNESS CENTER

PRINT PATIENT NAME: _____

DATE: _____

PATIENT SIGNATURE: _____

Integrated Medical Centers, Inc.
DBA: Quantum Medical and Wellness Center/Quantum Wellness Center
Doctors Lien/Lien on Recovery
To: Attorney/Insurance Carrier

_____

_____

From: Integrated Medical Centers, Inc.
DBA: Quantum Medical and Wellness Center/Quantum Wellness Center
1261 S. Pine Island Rd.
Plantation, FL 33324

I_____, (herein after patient), hereby assign to Integrated Medical Centers, Inc. /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center (herein after IMC.), all rights to payments and fees from patient's claim for a personal injury which occurred on or about _____ (herein after the claim) In an amount equal to all course of services provided to patient or patient's children, spouse, or legal charge, by Integrated Medical Centers, Inc., DBA: Quantum Medical and Wellness Center/Quantum Wellness Center and all their affiliates.

Patient here and expressively agrees not to revoke, modify or alter this agreement and the same shall remain a lien, not to be discharged until such time as Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Centers and all of IMC's affiliates are satisfactorily compensated for services rendered to patient or other persons pursuant to the patient/Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center contract.

Patient instruction authorizes the attorney_____, (herein after attorney) to make full payment directly and promptly to Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center for the amount obtained by attorney in the settlement, award, or judgment of the above named aforementioned claim. Patient understands this notice constitutes a lien in favor of Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center and all of IMC's affiliates on the proceeds of the patient's claim.

Patient understands that the patient's obligation is not contingent upon recovery, settlement, award or judgment and patient remains fully responsible to Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center or it's assigns for the amount secured by this agreement.

Patient hereby instructs that in the event another attorney is substituted or associated in this matter, the new attorney shall honor this lien as inherent to the settlement and

enforcers upon the cause or case as it were executed by him. This lien constitutes notice to any attorney responsible for the handling of this claim.

Patient herein and expressively relieves attorney of any duty to compromise this lien's inherent charges and give the attorney with the irrevocable duty to pay Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center, the lot, secured herein from the settlement, award or recovery of patient claim.

Patient herein acknowledges the patient has been apprised of the course diagnosis, treatment, reports, and fee and agrees to the amounts charged as is reasonable for services to be rendered by Integrated Medical Centers, Inc., /Quantum Medical and Wellness Center/DBA: Quantum Wellness Center. Patient further acknowledges that such services and treatment for injuries sustained as a result of the patients claim are not dependent upon patient signature herein and patient in turn understands this lien, having read it of the patient's own free will and with intent to be bound by the same.

Initial_____ Date _____

This lien does not waive other available remedies at law or in equity which Integrated Medical Centers, Inc., /Quantum Medical and Wellness Center/Quantum Wellness Center may have available. Patient expressively waives any statute of limitation, latches or other defenses to cause of action should it become necessary for Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center to in act other litigation to procure compliance with this agreement or patient's Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center contract.

Patient understands in the event the attorney does not sign this agreement, patient will still be bound by the provisions set forth.

Attorney is instructed by patient to promptly disclose to Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center any and all occurrences that may have a detrimental effect on the claim.

Attorney is instructed by the patient to serve a copy of this agreement on all counsel in the event of a substitution or association of another attorney having to notify Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center of said substitution immediately.

This agreement and the lien freely alienable and assignable by Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center and its patient's intent to have the provisions of this lien agreement bind patient and the patient's heirs as Integrated Medical Centers, Inc.'s heirs and assigns. If any legal action, arbitration or other proceedings is brought for the enforcement of this agreement or because alleged dispute, breach, default or misrepresentation in

connection with any of the provision of this agreement, the successful or prevailing party or parties shall be entitled to recover attorney's fees, legal interest, and other in current course in the acts in that action or proceeding in addition to any other relief to which it or they may be entitled. This lien or any part of the lien would be irrevocable and any remainder shall remain in full force and effect.

Patient acknowledges having received a copy of this agreement on the date below.

Patient: _____

Patient's Signature: _____

The attorney herby agrees to observe all terms set forth in this above agreement and agrees to withhold such sums from the settlement, award or assignment, as may be necessary to adequately or fully protect Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center.

Attorney further agrees to sign and return this agreement to Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center and a copy of said agreement to the patient within five working days of receipt of this lien agreement.

Attorney agrees to pay Integrated Medical Centers, Inc., /DBA: Quantum Medical and Wellness Center/Quantum Wellness Center's bill in full within 10 days of receipt of the settlement check, draft or any other payment to plaintiff's attorney. Including all medical payment benefits.

Dated: _____

Attorney's Signature: _____

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 if 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:_____