RELEVE
SPORTS MEDICINE

PATIENT INTAKE FORM

NAME: _____ **DATE:** _____

DOB: _____ **SEX:** _____

PRIMARY CARE DOCTOR AND LOCATION: _____

PREFERRED PHARMACY AND LOCATION: _____

HOW DID YOU HEAR ABOUT US? _____

WHAT ARE YOU BEING SEEN FOR TODAY? _____

PLEASE RATE YOUR CURRENT PAIN LEVEL: _____

PLEASE LIST CURRENT MEDICATIONS: _____

DO YOU HAVE ANY DRUG ALLERGIES? _____

ARE YOU ALLERGIC TO CHICKEN OR EGGS? _____

REVIEW OF SYSTEMS: CHECK THE BOX IF YOU HAVE RECENTLY HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:

Constitutional:
- ☐ Weight loss
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

Resp:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sputum production

Integ:
- ☐ Rash
- ☐ Itching
- ☐ Pain

Eyes:
- ☐ Pain
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Double vision

GI:
- ☐ Abdominal pain
- ☐ Blood
- ☐ Nausea/Vomiting
- ☐ Diarrhea

Neuro:
- ☐ Loss of consciousness
- ☐ Neck pain
- ☐ Numbness
- ☐ Tingling

ENMT:
- ☐ Sore throat
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nasal congestion

GU:
- ☐ Urinary frequency
- ☐ Urinary discomfort
- ☐

Psych:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Changes

Cardio/Vasc:
- ☐ Chest pain/discomfort
- ☐ Palpations
- ☐ Burning

MSK:
- ☐ Joint pain
- ☐ Swelling

Endo:
- ☐ Hot intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst

Heme/Lymph:
- ☐ Easy bruising
- ☐ Easy bleeding

MEDICAL HISTORY: CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS.

- ☐ Asthma
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Arthritis
- ☐ Stomach Ulcers
- ☐ Mental illness
- ☐ Kidney disease
- ☐ Cancer
- ☐ Bleeding disorder
- ☐ Lung disease
- ☐ Liver Trouble
- ☐ Seizures
- ☐ Mental illness
- ☐ Tuberculosis
- ☐ Anemia
- ☐ AIDS/HIV
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other

PLEASE LIST ANY PREVIOUS INJURIES, SURGERIES, OR HOSPITILIZATIONS (INCLUDE YEAR): _____

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FAMILY MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

	Mother	Father	Siblings	Children
Stroke	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Other:	☐	☐	☐	☐

SOCIAL HISTORY:

Occupation:
- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Students

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Living arrangements:
- ☐ Live alone
- ☐ Live with family
- ☐ Independent living/ assisted living facility

Do you smoke? _____

Do you consume alcohol? _____

Do you use drugs? _____

WOMEN ONLY:

Date of last menstrual cycle: _____

- ☐ Irregular periods
- ☐ Contraception
- ☐ Vaginal discharge
- ☐ Pregnant or nursing

PROFESSIONAL USE ONLY

BP: _____ PULSE: _____ RESP RATE: _____
TEMP: _____ HEIGHT: _____ WEIGHT: _____

VISON: LT_____ RT_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *

I. What this Is

This Notice describes the privacy practices of the Relevé Sports Medicine Clinic ("Clinic").

II. Our Privacy Obligations

The Clinic chooses to maintain the privacy of health information about you ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you and conduct our "clinic care operations" (e.g., internal administration, quality improvement, and customer service) as detailed below:

- Treatment. We use and disclose PHI to provide treatment and other services to you-for example, herbal treatments. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you. We may also disclose PHI to other practitioners involved in your treatment.

- Health Care Operations. We may use and disclose PHI for our clinic operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the treatment that we deliver to you. For example, we

may use PHI to evaluate the quality and competence of our practitioners, students, and providers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Office Manager.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition, or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer, as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials, as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner, as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye, or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person or the public's health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

M. Workers' Compensation. We may disclose PHI, as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs.

N. As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Use and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when you give us your authorization on our

authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

B. Special Authorization. Confidential HIV-related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, have HIV-related illness, or have AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your care, and, in certain limited circumstances, to public health or other government officials (as required by law), to persons specified in a special court order, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth in Florida State law). This special written authorization is a Florida State approved form which is a separate document from Your Authorization.

V. Your Individual Rights

A. For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to PHI, you may contact our Privacy Compliance Officers. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Compliance Officers will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with either us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment, and other treatment operations; (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care; or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Office Manager and submit the completed form to the Office Manager. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your treatment file maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Office Manager and submit the completed form to the Office Manager. If you request copies, we will charge you $.75 (seventy-five cents) for each page. We will also charge you for our postage costs, if you request that we mail the copies to you.

E. Right to Revoke Your Authorization. You may revoke Your Authorization or Your Special Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Office Manager identified below. [A form of Written Revocation is available upon request from the Office Manager.]

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your clinic record file. If you desire to amend your records, please obtain an amendment request form from the Office Manager and submit the completed form to the Office Manager. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to September 1, 2017. If you request an accounting more than once during a twelve (12) month period, we will charge you $.75 (seventy-five cents) per page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on September 1, 2017.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Clinics. You may also obtain any revised notice by contacting the Office Manager.

VII. Office Manager

You may contact the Office Manager at Relevé Sports Medicine, 5535 Cypress Gardens Blvd Suite 270, Winter Haven, FL 33884.

By signing below, I hereby acknowledge receipt of the Clinic's Notice of Privacy Practices.

_____ _____

Date Patient's Name

_____

Patient's Signature

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PATIENT INTAKE FORM

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, Relevé Sports Medicine Clinic ("Clinic") may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Clinics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Manager.

With my consent, the Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Clinics in carrying out TPO, such as appointment reminder, and any call pertaining to my clinical care. With my consent, the Clinic may mail to my home or other designated location any items that assist the Clinics in carrying out TPO, such as appointment reminder cards, as long as they are marked "Personal and Confidential".

I have the right to request that the Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the Clinic is not required to agree to my requested restrictions, but if it does, it is bound by this Agreement.

When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this Authorization in writing except to the extent that the Clinic has acted in reliance upon this authorization. My written revocation must be submitted to the Clinic's Office Manager at Relevé Sports Medicine, 5535 Cypress Gardens Blvd Suite 270, Winter Haven, FL 33884.

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By signing this form, I am consenting to the Clinic's use and disclosure of my PHI to carry out TPO.

_____ _____

Date Signature of Patient or Legal Guardian

_____

Relationship to Patient

_____

Print Name of Patient or Legal Guardian

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CONSENT FOR TREATMENT

I voluntarily consent to outpatient care and treatment performed by my physician and all other health care providers at Relevé Sports Medicine health care delivery sites. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider. I also understand that in the course of my medical treatment I may have one or more photographs of my skin, injury, or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive, and I consent to this, but I have the right at any time to object to letting such an individual observe and my objection will be honored.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent form also is an effort to obtain your permission to import your medication history as provided by SureScripts.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the

condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Printed Name of Witness	Employee Job Title

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PATIENT INTAKE FORM

Authorization for Release of Information to Family Members

Patient Name: _____ **DOB:** _____

We understand many patients allow family members such as spouses, parents, children, or others to be involved in their care plan, but due to requirements of HIPAA we are not allowed to give health information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form.

Upon signing this form, you authorize Relevé Sports Medicine to release medical and/or billing information to the following individual(s):

1. _____ Relation to Patient _____
2. _____ Relation to Patient _____
3. _____ Relation to Patient _____
4. _____ Relation to Patient _____

Patient Information

I understand I have the right to revoke this authorization in writing at any time.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature: _____ Date: _____