Manatee Medical Specialists dba Palma Sola Medical Associates

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PLEASE COMPLETE THE FOLLOWING PAPERWORK

- Patient registration sheet.
- Client Intake Form
- Assignment of Benefit Form [signature needed]
- HIPAA Privacy Form [signature needed]. This allows us to share your medical information, OR NOT SHARE, with specified family or friend[s]
- Medication list; name of drug/and dosage

If you are being seen in the office please bring completed forms, photo ID, and insurance cards with you.

If you are out of state being seen via telehealth, please send front/back of your insurance cards and complete the credit card information to be kept on file. **Fax c/o 941-761-3041 or email admin@myopaintherapy.com** [form use only, not for provider questions]

Name on Card: _____
Card Number: _____
Expiration date: _____ Security Code: _____
SIGNATURE: _____

PALMA SOLA MEDICAL ASSOCIATES REGISTRATION FORM

***Please PRINT. Complete ALL sections as this info will replace current data in your chart! ***

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

SOCIAL SECURITY NO: _____ DOB: ____/____/____ ☐ Male ☐ Female

ADDRESS: _____

☐ HOME PHONE: _____ ☐ CELL PHONE: _____ [Check Contact Preference]

EMAIL ADDRESS: _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

SPOUSES NAME: _____ CONTACT PHONE: _____

POLICYHOLDER NAME: _____ POLICYHOLDER DOB: ____/____/____

NORTHERN ADDRESS: _____

Dates of Northern Stay: FROM:_____TO: _____ NORTHERN PHONE: _____

EMPLOYER: _____ PHONE: _____

RACE: [check all that apply] ☐ White/Caucasian ☐ Black/African American ☐ Hispanic

☐ Asian/Pacific Islander ☐ Native American LANGUAGE PREFERENCE: ☐ English ☐ Spanish ☐ Other _____

ETHNICITY: ☐ NOT Hispanic or Latino ☐ Hispanic or Latino

IN CASE OF EMERGENCY CONTACT

NAME: _____ RELATION: _____ PHONE: _____

I AUTHORIZE PALMA SOLA MEDICAL ASSOCIATES TO ACCESS MY MEDICATION HISTORY ☐ YES ☐ NO

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for the balance. I also authorize Palma Sola Medical Associates to share medical information with insurance company/attorney necessary to process claims.

Patient or Guardian Signature: _____ Date: _____

C: My doc/registration form

Client Intake Form

Name: DOB: Today's Date:

Address:

City: State: Zip: Preferred Phone:

Email: Referred By:

Emergency Contact Name: Relationship:

Phone: Permission to Call: ☐Yes ☐No Restrictions:

Marital Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed ☐Other

Race/Ethnicity: ☐Hispanic/Latino ☐African American/Black/African/Caribbean ☐Asian/Pacific Islander ☐Caucasian ☐Native American ☐No Disclosure ☐Other

Medications:

Primary Care Provider: Phone:

Medical Illnesses/Surgeries:

Pregnancy History: #Live Births #Stillbirths #Miscarriages

Experienced the Loss of a Child

Nutrition Concerns:
Purge ☐Yes ☐No
Restrict ☐Yes ☐No
Overeat ☐Yes ☐No
Binge ☐Yes ☐No

Experiencing Pain: ☐Yes ☐No
Location of Pain:
How Long:
Medication for Pain:
Pain Level Today: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐+

Physical Symptoms:

☐ Headaches	☐ Sexual Problems	☐ Fainting
☐ Muscle Tension	☐ Skin Problems	☐ Fatigue
☐ Chest Pains	☐ Rapid Heart Beat	☐ Vision Changes
☐ Numbness	☐ Trembling/Shaking	☐ Blackouts
☐ Sweating	☐ Joint/Muscle Pain	☐ Chills/Hot Flashes
☐ Shortness of Breath	☐ Heat Pounding	☐ Stomach Aches
☐ Dizziness	☐ Diarrhea	☐ Nausea

Other:

Notes:

Client Intake Form

Top Three Stressors:

1.

2.

3.

Mood (Past 1-2 Weeks):	Behavioral Symptoms (Past Month):		Notes:
☐ Calm	☐ Sleep	☐ Appetite Change	
☐ Happy	☐ Enjoying Life	☐ Periods of High/Low	
☐ Sad	☐ Motivation	☐ Strange Thoughts	
☐ Angry	☐ Shame	☐ Strange Behavior	
☐ Anxious	☐ Guilt	☐ Low Energy	
☐ Frustrated	☐ Concentration	☐ Anxious	
☐ Worried	☐ Racing Thoughts	☐	
☐ Hopeless	☐ Lose of Sex Drive	☐	
☐ Helpless	☐ Impulsiveness	☐	
☐ Excited	☐ Fatigue	☐	
☐ Other	☐ Poor Judgment	☐	

Risk Assessment:	Yes	No	Recently	Today
Been so distressed you seriously wished to end your life?				
Do you have a specific plan how you would kill yourself?				
Do you have access to weapons/means of hurting self?				
Have you made a serious suicide attempt?				
Have you purposely done something to hurt yourself?				
Have you heard voices telling you to hurt yourself?				
Relatives who attempted or committed suicide?				
Thoughts of killing or seriously hurting someone?				
Heard voices telling you to hurt others?				

Any hospitalizations for Mental Health Purposes ? ☐ Yes ☐ No

If yes, when and for what reason?

Have you had any previous counseling? ☐ Yes ☐ No

If yes, with whom and when?

Social History:

Are your parents divorced? ☐ Yes ☐ No

Briefly describe your childhood (happy, chaotic, troubled):

Are childhood events contributing to current problems? ☐ Yes ☐ No

Have you experienced any abuse (physical, sexual, verbal ☐ Yes ☐ No

How satisfied are you with your current family life? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with the support received from family and friends? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with your quality of life? ☐ Satisfied ☐ Unsatisfied

Do you enjoy leisure/recreational actives? ☐ Yes ☐ No Why/Why Not

Are you Spiritual? ☐ Yes ☐ No If yes, importance to you?

Notes:

Client Intake Form

Education/Work History:

Years of Education? Degree(s)?

How many jobs held? Been Fired? ☐ Yes ☐ No

Do you have performance problems or difficulties with boss? ☐ Yes ☐ No

How satisfied are you with your current occupation? ☐ Satisfied ☐ Unsatisfied

Substance Use/Abuse:

	Yes	No	Past	Currently
Regularly use alcohol (more than twice a week)?				
Had trouble (legal, family, work) because of alcohol?				
Felt you should cut down on drinking?				
Felt bad or guilty about your drinking?				
Ever had a drink first thing in the morning?				
Use medications not prescribed to you?				
Taken more than the recommended daily dose?				
Used any product or other means to get "high"?				

Habits:

Do you smoke or chew tobacco regularly? ☐ Yes ☐ No If so, how much?

Do you drink caffeinated drinks regularly? ☐ Yes ☐ No If so, how much?

Do you exercise on a regular basis? ☐ Yes ☐ No If so, how much?

Do you have problems with gambling? ☐ Yes ☐ No

Do you have other potentially harmful habits you want to change? ☐ Yes ☐ No

Describe

Reason for Seeking Therapy:

Goals for Therapy:

1.

2.

3.

Client Signature Client Printed Name Date

Legal Guardian Signature Legal Guardian Printed Name Date

Palma Sola Medical Associates

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Palma Sola Medical Associates for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Palma Sola Medical Associates to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. The order will remain in effect until revoked by me in writing.

I have requested medical services from Palma Sola Medical Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Witness **Date**

PALMA SOLA MEDICAL ASSOCIATES ACKNOWLEDGEMENT OF PRIVACY ACT

Acknowledgment:

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices and Doc/ACO Program displayed in lobby.

PRINT NAME: SIGNATURE: Date:

AUTHORIZATION TO RELEASE OR NOT RELEASE MEDICAL INFORMATION

In accordance with HIPAA [Healthcare Portability Act of 1996] mandated by the government, **in order for our practice to discuss your condition with others, we must obtain your authorization to do so.** The law also stipulates that these rules may be waived due to the severity of your medical condition.

☐ I **DO NOT** AUTHORIZE THE PRACTICE TO RELEASE INFORMATION REGARDING MY MEDICAL CARE EXCEPT AS SET FORTH ABOVE.

☐ I **DO** AUTHORIZE THE PRACTICE TO RELEASE VERBALLY AND/OR PHOTOCOPIES OF MY MEDICAL CARE TO THE FOLLOWING INDIVIDUALS:

Name	**Phone**
Name	**Phone**
Name	**Phone**

PLEASE LIST NAME / DOSAGE OF ALL MEDICATIONS

Patient Name:

_____

_____

_____

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