Name: Date:

Patient Information

☐ **New Patient** ☐ **Returning Patient**

Last Name	First Name	Middle Initial

Date of Birth MM/DD/YYYY _____/_____/_____	Sex ☐ Male ☐ Female	Social Security #

Address	City	State	Zip Code

Primary Phone Number ☐ Home ☐ Work ☐ Cell	Secondary Phone Number ☐ Home ☐ Work ☐ Cell	Preferred Contact Method ☐ Phone call ☐ Text ☐ Email

Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Separated ☐ Partner	Email To be used for provider communication, follow up, patient portal, and practice related material. We DO NOT share email information with other parties. You may choose to remove at any time.	Employment Status ☐ Full time ☐ Part time ☐ Not employed ☐ Student ☐ Homemaker ☐ Retired

Preferred Language ☐ English ☐ Spanish ☐ Other	Employer	Job Title

Race ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Asian ☐ Black or African American ☐ Unreported	Preferred Pharmacy:

Insurance Information

Primary Insurance Company	
Name of Policy Holder ☐ Same as above	Policy Holder's Date of Birth ☐ Same as above ____/_____/_____

Policy Holder's Relationship to Patient ☐ Self ☐ Mother ☐ Father ☐ Other _____	Policy Holder's Social Security # ☐ Same as above

Subscriber Number	Group Number
Secondary Insurance Company ☐ N/A	Name of Policy Holder ☐ Same as above
Secondary Subscriber Number	Secondary Group Number

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following listed

Name	Relationship	Phone Number	Yes or No

Name: Date:

In Case of Emergency

Reason For Today's Visit

Chief Complaint (please describe symptoms)	
☐ Medical Treatment (list symptoms above) ☐ Physical - ☐ School ☐ Work ☐ DOT ☐ Work Related Injury – Worker's Compensation ☐ Pre-op Medical Clearance ☐ Car Accident or Auto Related Injury ☐ Unknown Cause ☐ Home Injury ☐ Other _____	Onset/Injury Date
Please report previous treatment received for condition ☐ Emergency Room ☐ Prescribed Medication ☐ Surgery ☐ Ice ☐ Other: _____ ☐ Physical Therapy ☐ Over-the-counter Medication ☐ Rest ☐ Heat ☐ Other:	

Current Medications Prescribed by Another Provider or anything you are taking over the counter

Medication	Dosage	Condition

Medical History (check all that apply)

☐ ADD/ADHD	☐ Chronic Fatigue Syndrome	☐ Hearing Impairment	☐ Pacemaker
☐ AIDS/HIV	☐ Constipation	☐ Heart Disease	☐ Parkinson's Disease
☐ Allergies	☐ COPD	☐ Heart Murmur	☐ Pinched Nerve
☐ Alzheimer's/Dementia	☐ Depression	☐ Hepatitis	☐ Scoliosis
☐ Anemia	☐ Diabetes: Insulin / Non-	☐ Herniated Disk	☐ Seizure Disorder
☐ Appendicitis	☐ Ear Infections	☐ Herpes/Lesions/Shingles	☐ Sinusitis
☐ Arthritis	☐ Eating Disorder	☐ High Blood Pressure	☐ Sleep Apnea

Name: Date:

☐ Asthma	☐ Eczema	☐ High Cholesterol	☐ STD
☐ Autoimmune Condition	☐ Eye Problems	☐ Hypoglycemic	☐ Stroke/ TIA
☐ Back Pain	☐ Fainting /Syncope	☐ Influenza/ Pneumonia	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Joint Pain	☐ Tonsillitis
☐ Bronchitis	☐ Fractures	☐ Kidney Disease/ Stones	☐ Tumors/Growths
☐ Cancer: _____	☐ Gallbladder Disorder	☐ Measles/ Mumps/ Rubella	☐ Ulcers
☐ Cataracts	☐ Glaucoma	☐ Miscarriage	☐ Vaginal Infections
☐ Chest Pain	☐ Gout	☐ Mononucleosis	☐ Vertigo
☐ Chicken Pox	☐ Headaches	☐ Osteoporosis	☐ Other:

Allergies

Medication Allergies:	Reaction:
Supplement Allergies:	Reaction:
Food Allergies:	Reaction:
Other:	Reaction:

Surgical History (check all that apply)

☐ Angioplasty	☐ Debridement	☐ Lumpectomy
☐ Arthroscopy	☐ Dilation and Curettage	☐ Mastectomy
☐ Appendectomy	☐ Ear Tubes	☐ Pacemaker/Defibrillator
☐ Biopsy (site):	☐ Eye Surgery (specify):	☐ Skin Lesion Removal
☐ Bunionectomy	☐ Gallbladder Removal	☐ Spinal Surgery (type):
☐ Cardiac Surgery (type):	☐ Gastric Bypass	☐ Thyroid Surgery
☐ Carpal Tunnel	☐ Hernia	☐ Tonsillectomy
☐ Cesarean Section	☐ Hysterectomy	☐ Tubal Ligation
☐ Colostomy	☐ Joint Replacement	☐ Vasectomy
☐ Cosmetic (type):	☐ Kidney Surgery	☐ Other:
Any hospitalizations besides surgeries?		

Family History Please Circle: Mother: Alive/Deceased Father: Alive/Deceased

Check all that apply. Please indicate family member associated with condition: M-Mother, F- Father, S-Sister, B- Brother, MG- Maternal Grandmother, MF- Maternal Grandfather, MA- Maternal Aunt, MU- Maternal Uncle, PG- Paternal Grandmother, PF- Paternal Grandfather, PA- Paternal Aunt, PU- Paternal Uncle, C- Child

Name: Date:

Condition	Family Member	Condition	Family Member	Condition	Family Member
? ADD/ADHD		? Diabetes		? Obesity	
? Alcoholism/Substance Abuse		? Eczema/Psoriasis		? Parkinson's Disease	
? Alzheimer's/Dementia		? Heart Disease		? Psychiatric Disorder	
? Arthritis		? Hemodialysis		? Seizure Disorder	
? Asthma		? Hepatitis		? Stomach or GI problems	
? Auto Immune Disease (ex: Lupus)		? High Blood Pressure		? Stroke/TIA	
? Cancer (type):		? High Cholesterol		? Thyroid Problems	
? COPD		? Kidney Disease		? Other:	

Social History

Exercise Habits: ? Daily ? Minimal ? 3-4 x per week ? None ? 1-2 x per week ? None Due to Injury/ Illness	Tobacco Use: ? Never Smoked ? Smokeless Tobacco ? Current Smoker ? Vaporizer ? Former Smoker Amt/Day _____ # of years _____	Alcohol Use: _____ Drinks Per Week Caffeine Use: _____ Cups Per Day
Drug Use: ? No history of recreational drug use ? Former use of recreational drugs ? Current use of recreational drugs	Work Habits: ? N/A Average # of hours per week _____ Mostly- ? Sitting ? Standing ? Walking Labor- ? Sedentary ? Light ? Moderate ? Heavy Environment- ? Difficult ? Stressful ? Relaxed ? Enjoyable	

Review of Systems (check all that apply)

CONSTITUTIONAL	ENDOCRINE	HEMATOLOGY/LYMPH	CARDIOVASCULAR
? Weight Loss ? Fatigue ? Fever	? Loss of Hair ? Heat/Cold Intolerance	? Bruising ? Gums Bleed Easily	? Murmur ? Chest Pain ? Palpitations
EYES	**GASTROINTESTINAL**	**MUSKULOSKELETAL**	? Dizziness ? Fainting Spells ? Shortness of Breath ? Difficulty Lying Flat ? Swelling Ankles
? Glasses/Contacts ? Eye Pain ? Double Vision ? Cataracts	? Heartburn/Reflux ? Nausea/Vomiting ? Constipation ? Change in bowel movements	? Joint Pain Swelling ? Stiffness ? Muscle Pain ? Back Pain	

Name: Date:

EAR, NOSE, THROAT	GENITOURINARY	NEUROLOGICAL	ALLERGIC/IMMUNOLOGIC
? Difficulty Hearing	? Burning/Frequency	? Loss of Strength	? Hives
? Ringing in the Ears	? Night Time	? Numbness	? Eczema
? Vertigo	? Blood in Urine	? Headaches	? Hay Fever
? Sinus Trouble	? Erectile Dysfunction	? Tremors	
? Nasal Stiffness	? Abnormal Discharge	? Memory Loss	
? Frequent Sore Throat	? Bladder Leakage		
RESPIRATORY	**PSYCHIATRIC**	**SKIN**	
? Cough Easy	? Anxiety/Depression	? Rash/Sores	
? Wheezing	? Mood Swings	? Lesions	
? Chills	? Difficulty Sleeping	? Itching/Burning	

Ownership Notice to Patients

Name: Date:

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of1992," FL Statute Section 455.654).

Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Robert McLaughlin has an ownership in: Back In Action Medical Center, LLC, Proactive Health and Wellness, dba Back In Action Chiropractic, and Access 365 Urgent Care, PMB Health Solutions LLC/dba Back In Action Chiropractic, and M&R Wellness Center, LLC/ dba Back In Action Chiropractic

Dr. Michael Purificati has an ownership in PMB Health Solutions LLC/dba Back In Action Chiropractic and M&R Wellness Center LLC/dba Back In Action Chiropractic

Alternative Medical facilities in which we do not have ownership:

1. Jensen Beach Urgent Care
2. Med Stat Urgent Care
3. Martin County Department of Health
4. Dr. G's Urgent Care
5. Helix Urgent Care

Alternative Chiropractic facilities in which we do not have ownership:

1. Complete Care Chiropractic
2. Life Chiropractic
3. Vital Wellness Center
4. Keystone Chiropractic
5. Hoffman Chiropractic

Patient Name _____

Signature _____

Date _____

If not patient, name of legal guardian:_____Relationship_____

Name: Date:

Medical Information Release Form

(HIPAA Release Form)

This ***Release of Information*** will remain in effect until terminated by me in writing.

Name: _____ Date of Birth: _____

Release of Information

[] I authorize the release of information including the diagnosis, records;

Examination rendered to me and claims information. This information may be released to:

[] Spouse_____

[] Child _____

[] Other _____

[] Information is not to be released to anyone

Messages

Please call [] my home [] my work [] my cell number: _____.

If unable to reach me:

[] you may leave a detailed message

[]please leave a message asking me to return your call

[] _____.

The best time to reach me is (day) _____ between (time) _____.

I authorize the release of my Medical Records VIA Email. ____Yes____No

Email Address:_____

Signed: _____ Date:__/__/_____

Witness: _____Date:__/__/_____

Name: Date:

When an appointment is scheduled for you with one of our providers at Back in Action/Best Life Primary Care, it is your responsibility to confirm your appointment 24hrs prior to the appointment time. The front desk team will call and or email you to confirm your appointment. In the event you do not answer a voice mail will be left. If you as the patient do not make confirmation of your scheduled appointment by 5pm day prior your appointment will be canceled and rescheduled for a later date. If you have an appointment scheduled and you do not show up, you will be billed a $50.00 no show fee. We understand that circumstances will arise that will result in you having to cancel, please give us a courtesy call 24hrs prior to your scheduled time to prevent the no show fee being charged.

We value you as one of our patients and hope you understand why this is a necessary office policy.

Please sign and date below stating your acknowledgement of this policy.

Print Name:_____

Signature:_____

Date:_____

Name: Date:

BACK IN ACTION MEDICAL CENTER

PRIVACY & BILLING PROCEDURES
AUTHORIZATION & ACKNOWLEDGEMENT

These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all future dates of service. You may submit written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Back In Action Medical Center reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have had the opportunity to read or have received a copy of the Notice of Privacy Practices for the patient outlined above.

AUTHORIZATION TO TREAT & BILL

I give consent and authorization to Back In Action Medical Center to examine and provide all routine medical care, diagnostic procedures, disposing of any specimens or tissue taken from my body, and provide treatment in the judgment of the medical provider, necessary or beneficial to my health and well-being with no guarantees expressed regarding the results of examination and treatment by aforementioned facility.

I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to Back In Action Medical Center for all services performed.

I understand that I am responsible for all charges incurred at the time of service unless other arrangements were made prior to being treated. I will pay any deductible, co-payments, and any amounts denied or not covered by insurance. I understand it is my responsibility to check with my insurance carrier prior to my visit for covered and non-covered benefits and also whether or not Back In Action Medical Center visit will be paid with my in-network or out-of-network benefits billed as urgent care place of service (POS 20).

I understand that if I do not provide complete and accurate billing/insurance information at the time of service and this lack of information prevents Back IN Action Medical Center from collecting from my insurance company, I will be responsible for the full charges. If a referral or additional forms are required by my insurance company, I understand I am responsible for providing Back In Action Medical Center with a referral within 48 hours of my visit and/or complete all insurance required forms in a timely manner, or I may be responsible for all charges.

Collection Fees: If payment is not made as agreed upon, the account will be turned over for collection. The patient and/or guarantor, shall be responsible for and agree to pay all reasonable cost of collection including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs.

Jurisdiction and venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Martin County, Florida, and waives any objection to jurisdiction or venue.

Assignment & Release: I hear by request and assign directly to Back In Action Medical Center all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including collection fees and/or interest that may accrue, whether paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits unless written notice is given to revoke this authorization. I authorize the use of a copy of this signature as valid as the original signature on all of my insurance submissions. Co-pays and Quick Pay fees are due at the time of service. All account balances will be the patient's and/or guarantor's responsibility after processing of insurance, if applicable, and may be assessed and $15.00 statement fee per invoice. Full balance is due within 15 days or upon receipt of the first invoice.

- **PLEASE SIGN HERE: PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE:_____ DATE:_____**

OUTSIDE LABORATORY AND RADIOLOGISTS

It is my understanding that Back IN Action Medical Center may send lab specimens to an outside laboratory or send x-rays taken by Back In Action Medical Center to an outside radiologist for over reading. I give permission for those outside laboratories and radiologists to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests or radiologists. I understand that Back In Action Medical Center is not responsible for payment to those laboratories and/or radiologists.

- **PLEASE SIGN HERE: PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE:_____ DATE: _____**

NON-COVERED SERVICES

It is my understanding that my insurance company may deem my visit to Back In Action Medical Center as a non-covered service and may make me fully responsible for payment of all charges for these services.

PLEASE SIGN HERE: PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE:_____ DATE:_____

Name: Date:

Controlled Substance Agreement

This agreement is designed to ensure the safe and appropriate use of controlled substances prescribed by Back in Action Medical Center/Best Life Primary Care. Controlled substances include, but are not limited to, medications such as Xanax, Tramadol, Ambien, Adderall, and similar classes of controlled substance medications.

In accordance with Federal and state law §456.44(3), F.S. which establishes Standards of Practice for physicians prescribing controlled substances, patients must see the physician at regular intervals not to exceed 3 months.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Purpose of Agreement: This agreement outlines the responsibilities of both the patient and the medical provider to ensure the responsible use of controlled substances.

1. Patient Responsibilities: 1.1. I understand that controlled substances are prescribed to manage specific medical conditions, and that misuse can lead to serious health risks, including dependency or addiction.
1.2. I agree to take medications exactly as prescribed. I will not alter the dosage or frequency without prior consultation and approval from my healthcare provider.
1.3. I will not share, sell, or trade my medication with anyone under any circumstances.
1.4. I will safeguard my medication to prevent loss or theft. I understand that lost or stolen medications will not be replaced.
1.5. I agree to use only one pharmacy for filling prescriptions for controlled substances. My pharmacy is: Pharmacy Name: _____

Phone Number: _____

1.6. I agree to provide a complete list of all medications I am taking, including over-the-counter drugs, supplements, and other prescriptions.
1.7. I will not seek prescriptions for controlled substances from other healthcare providers without informing Back in Action Medical Center/Best Life Primary Care.
1.8. I understand that I may be asked to provide a urine drug screen (UDS) or other tests to monitor my medication use.
1.9. I understand that early refills will not be authorized.

2. Provider Responsibilities: 2.1. The provider will evaluate the patient's medical condition and determine the appropriate treatment, including prescribing controlled substances if necessary.
2.2. The provider will educate the patient about the benefits, risks, and alternatives to using controlled substances.
2.3. The provider will monitor the patient's condition regularly and adjust treatment as necessary.
2.4. The provider will maintain a confidential medical record of all treatments and prescriptions.

2.5. The provider reserves the right to discontinue prescribing controlled substances if the patient violates this agreement or if it is deemed clinically inappropriate to continue.

Name: Date:

3. Termination of Agreement: This agreement may be terminated under the following circumstances:

- Failure to comply with any part of this agreement.
- Abnormal findings on drug testing (e.g., presence of non-prescribed substances or absence of prescribed substances).
- Evidence of misuse, abuse, or diversion of prescribed medications.
- Threatening or abusive behavior towards clinic staff.

4. Acknowledgment and Consent: By signing this agreement, I acknowledge that I have read, understood, and agreed to the terms outlined above. I consent to the use of controlled substances as part of my treatment plan and agree to adhere to the responsibilities described in this document.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Name: Date:

Consent for Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM) Services

As part of an ongoing effort to enhance care coordination for its beneficiaries, **Medicare and other commercial insurance companies** offer **Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM)** services. These programs are designed to improve the coordination of your care, helping you manage chronic or complex health conditions more effectively.

Each program provides **non-face-to-face care management services** to support your healthcare needs between office visits. These services **complement in-person visits** and ensure that you receive continuous support for managing your health.

Eligibility Requirements:

- **CCM**: Requires **two or more chronic conditions** expected to last at least 12 months and place you at significant risk of functional decline or death.
- **PCM**: For **patients with a single high-risk chronic condition** that requires regular care coordination and oversight.
- **APCM**: A more advanced level of primary care management aimed at patients needing **comprehensive oversight** due to complex health conditions.

Services Provided by Back in Action Medical Center / Best Life Primary Care

If you qualify for any of these programs, our healthcare team will:

- ✔ **Develop a comprehensive care plan**, available to you in written or electronic form and updated as needed.
- ✔ **Coordinate with other healthcare providers** involved in your care, ensuring seamless communication in compliance with state and federal privacy laws.
- ✔ **Assist with care transitions**, such as referrals, emergency department follow-ups, and post-hospital discharge management.
- ✔ **Provide 24/7 access to our care team** for urgent chronic care needs and ongoing coordination.
- ✔ **Review and track your key health information**, including lab results, medications, allergies, and preventive care reminders.

Name: Date:

Consent & Billing Acknowledgment

By signing this consent, you agree to:

✅ Allow **Back in Action Medical Center / Best Life Primary Care** to bill Medicare or your commercial insurance for **CCM, PCM, or APCM services** on your behalf. These services may be billed once per month, even if you do not have an in-office visit.

✅ Pay applicable copayments and deductibles for these services. The estimated cost for **Traditional Medicare patients** is **$13.00 - $35.00 per month**, while commercial insurance plans may have varying costs based on copay/coinsurance policies.

✅ Acknowledge that **only one provider can bill for these services per month**—if another provider is already furnishing CCM, PCM, or APCM for you, please notify us.

✅ Authorize **electronic communication of your medical information** with your care team and treating providers as part of coordinated care efforts.

✅ You have the right to stop receiving services at any time (effective at the end of a calendar month) and can do so by notifying Back in action medical center/Best life Primary care of your decision, at which point we will have you sign a termination form.

I permit Back in action medical center/Best life Primary care to bill Medicare and Any Commercial Insurance for Chronic Care Management Services provided to me and understand I will be responsible for applicable co-payments and deductibles.

Name: _____ Date: _____

Signature: _____Date: _____

Name: Date:

I hereby consent to the use of Artificial Intelligence (AI) technologies during my office visits at Back In Action Medical Center d/b/a Best Life Primary Care and Access 365 Urgent Care. I understand and acknowledge the following:

1. Purpose: The purpose of integrating AI into my healthcare is to enhance the quality and efficiency of medical services provided to me. AI may assist in various aspects of diagnosis, treatment planning, and monitoring of my health condition.

2. Understanding: I understand that AI technologies may analyze my medical history, symptoms, diagnostic test results, and other relevant data to assist healthcare providers in making informed decisions regarding my care.

3. Privacy and Confidentiality: I acknowledge that my personal health information may be used in conjunction with AI technologies. Back In Action Medical Center d/b/a Best Life Primary Care and Access 365 Urgent Care will maintain the confidentiality and security of my health data in accordance with applicable laws and regulations.

4. Limitations: I understand that AI technologies are tools to aid healthcare professionals and may have limitations. The final decision regarding my diagnosis and treatment will be made by my healthcare provider(s) based on their clinical judgment and expertise.

5. Opting Out: I understand that I have the right to opt-out of the use of AI during my office visits. Such opt-out request must be submitted in writing to Back In Action Medical Center d/b/a Best Life Primary Care and Access 365 Urgent Care. I understand that opting out may impact the quality or efficiency of the healthcare services provided to me.

6. Education and Communication: Upon request, Back In Action Medical Center d/b/a Best Life Primary Care and Access 365 Urgent Care will provide me with information and resources to better understand how AI technologies are used in my care. I will also have the opportunity to ask questions and discuss any concerns I may have regarding the use of AI.

By signing below, I acknowledge that I have read and understood the information provided in this consent form. I voluntarily consent to the use of Artificial Intelligence during my office visits atBack In Action Medical Center d/b/a Best Life Primary Care and Access 365 Urgent Care.

Patient Name:_____ Signature:_____Date:_____

Name: Date:

Informed Consent For Disclosure Of Medical Health Information

Patient Name:_____ Former Name:_____

Date Of Birth:_____

I Authorize the Following Health Care Provider:

Disclosing Party's Name (health care Provider)_____

Street Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

To Disclose to the following Party:

Disclosing Party's Name (health care Provider)_____

Street Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

__These Records Are Needed For AN Appointment on_____

Requesting The Following Information:

__Last (2)Office Notes __Lab Reports __Imaging Reports __EKG

__Other:_____

Disclosure is Being Made For the Following Purpose:

__Continuing Care __Insurance/Claims __Legal __Personal Information __Other:_____

Patient/Legal Representative Signature:_____ **Date:**_____