Heim
Regenerative
Medicine Center
Repair | Restore | Revive

Notice of Initiation of Treatment

Claim Number_____ Date _____

Patient/Claimant Name: _____

Patient/Claimant Signature: _____

Practice/Provider Name: Heim Regenerative Medicine Center

First Treatment Date: _____

TO WHOM IT MAY CONCERN:

This document shall serve as our formal Notice of Initiation of Treatment pursuant to Florida Statute §627.736 (5) (c). This notice is being sent, pursuant to Florida Statues, within 21 days after this facility's first examination or treatment of the above-referenced claimant.

Because this notice has been timely provided, the law allows statements from this provider to include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement sent.

Please take note and govern yourself accordingly.

Respectfully,

Heim Regenerative Medicine Center

By: _____
Michael P. Heim, DO

608 South Tampania Ave
Tampa Florida 33609

Phone: (813) 384-3107
Fax: (813) 876-3108

tampahealthcenter.com
info@tampahealthcenter.com

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Letter of Protection

To:

I hereby authorize and direct my attorney to pay directly to Heim Regenerative Medicine Center such sums as may be due for services rendered to me by reason of the injury occurring on the _____ day of _____, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Heim Regenerative Medicine Center. I hereby further give a lien on my case to Heim Regenerative Medicine Center against any and all of any settlement, judgement or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to Heim Regenerative Medicine Center for all medical bills submitted for services rendered to me and that this agreement is made solely for Heim Regenerative Medicine Center additional protection and in consideration for their awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may be eventually recover said fee.

I authorized the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bills.

Dated: _____

Patient Signature: _____

Patient's Name: _____
(Please Print)

The undersigned attorney of record for the above patient does hereby agree to observe all of the terms of the above, and agrees to withhold sums from any settlement, judgement, or verdict as may be necessary to adequately protect Heim Regenerative Medicine Center.

Dated: _____

Attorney's Signature: _____

Attorney's Name: _____

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Insurance Verification Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Social Security No: _____

Home Phone # _____ Work # _____ Cell # _____

PIP _____ W/C _____ Reg. Health Insurance _____ Date of Injury _____

Injured in Florida: (Yes) _____ (No) _____

At the time of the accident, were you the: Driver _____Passenger_____ Pedestrian _____

Do you own the vehicle: (Yes) _____ (No) _____

If Yes: Year_____ Make _____ Model_____

Year_____ Make _____ Model_____

If you do not own a vehicle, do you reside with a resident relative that owns a vehicle?

(Yes) _____ (No) _____

If yes, who insures that the resident relative's vehicle: _____

Have you reported the claim: (Yes) _____ (No) _____If yes, what is the date you reported the claim? _____

Insurance Carrier: _____ Phone _____

Address_____

Claim Number_____ Policy Number_____

Adjuster's Name _____ Phone _____ Fax_____

Referred by _____ Phone _____

Auto Carrier: Pays @_____% Deductible $_____ ($) _____ Med Pay_____

Attorney _____ Phone _____ Fax _____

Address _____

Lop Requested on _____ Received on _____

Did we obtain copy of Insurance card? (Yes) _____ (No) _____ If not, why? _____

_____

Other: _____

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PRIMARY CARE PATIENT INFORMATION FORM

Date:_____

PATIENT INFORMATION

Last Name_____ First Name _____Middle_____

Date of Birth _____/_____/_____ Age_____ Sex: M / F Marital Status: M S D W

Social Security Number _____ Email Address_____

Home Address: _____

City_____ State _____ Zip_____

Phone: Home _____Work _____Cell _____

REASON FOR VISIT / MAIN CONCERN_____

Primary Care Physician_____ Date of Last Physical_____

PRESCRIPTION MEDICATIONS *(PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)*

1.	4.
2.	5.
3.	6.

NON PRESCRIPTION MEDICATIONS *(LIST OVER THE COUNTER, HERBAL, AND VITAMINS)*

1.	3.	5.
2.	4.	6.

DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS?

NO_____ YES_____

MED:_____ REACTION:_____

MED:_____ REACTION:_____

MED:_____ REACTION:_____

REVIEW OF SYSTEMS: *(PLEASE CIRCLE IF YOU HAVE /HAVE HAD IN THE PAST 12 MOS)*

GENERAL	EYES	EAR, NOSE,THROAT	SKIN
Weight Loss	Double Vision	Hearing Loss	Bruise Easily
Fever	Dry Eyes	Ringing in Ears	Rashes
Night Sweats	Redness	Sore Throat	Change in Moles
Depression	Pain	Bloody Nose	Hair loss/thinning hair

CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	URINARY
Heart Palpitations	Chronic Cough	Constipation	Frequent Urination
Chest Pain	Bloody Sputum	Diarrhea	Blood in Urine
Heart Racing	Shortness of Breath	Blood in Stools	Painful Urination
Ankle Swelling	Wheezing	Excessive Thirst	Lack of Control

NEUROLOGICAL	MUSCULOSKELETAL	HEMATOLOGIC	ALLERGIC
Headaches	Joint Pain	Bleeding Gums	Swelling
Dizziness	Muscle Pain	Unexplained Bleeding	Hives
Numb Arms/ Legs	Weak Arms/Legs	Transfusion	Redness/ Scaling

IF NONE OF THESE APPLY, PLEASE INITIAL HERE: _____

PLEASE CIRCLE ALL THAT YOU HAVE EXPERIENCED IN THE PAST 12 MONTHS

Decreased libido	Night sweats	Hot flashes	Irritability
Fatigue after meals	Insomnia	Erectile problems	Exercise intolerance
Swelling	Cold intolerance	Brittle hair/nails	Dry/flaky skin

Past Medical History: Please circle if you have or have ever been diagnosed with any of the following conditions:

Heart Disease	Diabetes	Asthma or Emphysema
High Blood Pressure	Arthritis	Hepatitis or Liver Disease
Depression/Anxiety	HIV or AIDS	Alcohol or Drug Dependency
Thyroid Problems	Kidney Disease	Tuberculosis
Sleep Apnea	Osteoperosis	PCOS
High Cholesterol		

Cancer (Type and Treatment)_____

Other (Please Specify)_____

When was your last:

Colonoscopy _____ Prostate Exam/PSA_____ PAP _____

Menstrual Cycle _____ Mammogram _____

PAST SURGICAL HISTORY:

Date_____ Surgery_____ Dr._____

Date_____ Surgery_____ Dr._____

Date_____ Surgery_____ Dr._____

SOCIAL HISTORY:

Do you smoke? (YES)____ (NO) ____

(How Much?) _____ Quit? (When?) _____

Do you drink Alcohol? (NO) _____ (OCCASIONALLY) _____ (DAILY) _____

What is your weight?_____ For you, is this Low_____ Normal _____High_____

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

- ☐ Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- ☐ Atherosclerosis (hardening of the arteries) _____
- ☐ High cholesterol or other form of abnormal lipids _____
- ☐ Heart attack or stroke _____
- ☐ Diabetes or any form of metabolic disease or obesity _____
- ☐ Cancer and list type(s) _____
- ☐ Osteoporosis or any form of bone disease _____
- ☐ Thyroid disease _____

List any other diseases in your family or additional information you think we should know:

_____

_____

_____

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY MEDICAL CARE AND I, THEREFORE, CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Name:_____ Signature:_____ _____ Date:_____

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HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? _____Yes _____No Ok to leave message? _____Yes _____No

May we contact you at work? _____Yes _____No Ok to leave message? _____Yes _____No

May we contact you via cell? _____Yes _____No Ok to leave message? _____Yes _____No

Is it ok to leave a message that includes:

Practice name and phone number only? _____Yes _____No

Detailed or specific message? _____Yes _____No

Would you like to authorize someone else to schedule, confirm, or change appointments?_____Yes _____No
If so, please provide:

Name _____ Phone _____

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name _____

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? _____Yes _____No

HOW DID YOU HEAR ABOUT US?

___ Friend or Family Member (Name) _____
___ Website: ___ *Tampahealthcenter.com* ___ BCBS Website
___ Internet Search (Google / Yahoo / Other) _____
___ Newspaper/Newsletter or Mailer _____
___ An Article or Advertisement in _____
___ Other _____

Michael P. Heim, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on his website www.tampahealthcenter.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

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AUTHORIZATION TO PAY MEDICAL OR SURGICAL BENEFITS DIRECTLY TO PHYSICIAN:

I hereby authorize my insurance company (*Please print name of insurance company),* _____, to make payments directly to Michael P. Heim, DO, of *The Center for Health and Age Management*, for all medical expense benefits otherwise payable to me for this period of treatment. Any remaining balance due *The Center for Health and Age Management* will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: *you are required to pay in full at the time of your visit; we will file your medical claim with your insurance company as a courtesy, and, after receiving an Explanation of Benefits (EOB) from your insurance company, any credits will be refunded to you by your insurance plan or our office. It is in your best interest to understand your insurance plan.*

INSURANCE MEMBER ID#: _____ GROUP #:_____

PRIMARY INSURED NAME: _____ DATE OF BIRTH:_____

PROVIDER SERVICES/CUSTOMER SERVICE PHONE NUMBER: _____

* *The Center for Health and Age Management* currently participates with BCBS PPO and TriCare Standard. This is subject to change at any time without notice. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize release of my records to the insurance company for the purpose of billing.

I authorize *The Center for Health and Age Management* to charge outstanding balances on my account and refills for compounded medication (if applicable) to the following credit card. If the billing address for this card differs from your home address, please advise the billing address. Thank you.

Visa _____ MC _____ Discover _____ HSA* _____

Account Number: _____ Exp. Date: _____ Security Code: _____

Name on Card (PRINT): _____ _____

Patient Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

_____ _____ _____

Patient Name *(Please Print)* Patient/Parent/Guardian Signature Date

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