GULFCOAST HEALTHCARE GROUP

Larry Johnson DC
Aaron Wohl MD
Suzanne Bryce MD

Cape Coral Surgery Center
2721 Del Prado Blvd. S., #250
Cape Coral, FL 33904
239-574-5559 • Fax 239-574-9454

Kane Plaza
1 S. School Ave., #601
Sarasota, FL 34237
941-308-9484 • Fax 941-308-9480

Patient Name:____Date:____________________
DOB: _______________________Age:_______________SS#/SIN:______________________________
Phone Number: __________________Work:__________________Email:_________________________
May we Leave Messages/texts on this phone # Yes No
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Home Address: ____
City:____________________________________State:___________Zip:______________________
Gender: ☐ Male ☐Female
Employer Name: ____
Spouse or Patient's Guardian: ____
Whom may we thank for referring you? ____
DNR: ☐ Yes ☐ No (If yes, bring paperwork)
Advanced Directives: ☐ Yes ☐ No (if yes, bring paperwork)
Emergency Contact: ____
In an emergency and the patient is a minor, it is okay for us to treat in absence of parents;

____ _________________________
Parent/Guardian Signature Date

Responsible Party (Complete if different from above)
Name of The Person responsible for this account: ____________________________________
Relationship to Patient____
Address: ____
Home Phone: ____________________________Cell Phone: __________________________________
Driver's License # ____
DOB:____
Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical Insurance? ☐ Yes ☐ No (if yes, provide the card)
Name: of the insured____
Relationship to patient_____________________________ DOB: ___________________________
Name of Employer_______________________________ Work Phone: __________________________
Address of Employer____
City:____________________________ State:____________ Zip:_____________________________
Insurance ID Number: __________________Group # ____________Union or local #_______________
Ins. Co. Address:____
City: _____________________________ State:__________ Zip: _____________________________

Health History

Chief Complaint:____

History of Chief Complaint:

Location: ______________________ (Where is the pain/problem?)

Quality: ______________________ (aching, throbbing, stabbing, burning, shooting, etc.)

Severity: ______________________ (Scale of 1-10, 10 is worst pain)

Duration: ______________________ (How long have you had pain?)

Timing:______________________ (Does the pain/problem occur at specific times?)

Context:______________________ (What makes the pain/problem worse/better?)

Influential Factors:______________________ (What aggravates the pain? What alleviates the pain?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" / leave blank if you are uncertain.)

Anemia:	YES / NO	Gout:	YES / NO	Back Trouble:	YES / NO
Hepatitis:	YES / NO	Anxiety:	YES / NO	Bladder Infection:	YES / NO
COPD:	YES / NO	Ulcers:	YES / NO	Depression:	YES / NO
High Blood Pressure:	YES / NO	A-Fib:	YES / NO	Bipolar:	YES / NO
Epilepsy:	YES / NO	Migraines:	YES / NO	Kidney Disease:	YES / NO
Fibromyalgia:	YES / NO	Tuberculosis:	YES / NO	Hemorrhoids:	YES / NO
Thyroid Issues:	YES / NO	Incontinence:	YES / NO	Stroke:	YES / NO
Bleeding Tendency:	YES / NO	Cancer:	YES / NO	Seizures:	YES/ NO
Blood Thinners:	YES/NO	Diabetes:	YES/ NO	Hernia:	YES / NO
Asthma:	YES / NO	Pneumonia:	YES / NO	Mood Disorders:	YES / NO
Hives or Eczema:	YES / NO	Glaucoma:	YES / NO	Shingles:	YES / NO
AIDS/HIV:	YES / NO	Bronchitis:	YES / NO	Thrombophlebitis	YES / NO
Arthritis:	YES / NO	Implantable Device	YES / NO	Herpes Simplex	YES / NO
Congestive Heart Failure:	YES / NO				
Deep Vein Thrombosis:	YES / NO				

Have you ever been told you take longer than normal to heal? YES / NO

Any Other Disease/Conditions:____

Previous Surgeries

What Surgery?	When?	Hospital, City, State

Medications: (include nonprescription/ supplements/ vitamins and include dose and how often. may include extra page if needed)

____

Allergies: (including medication allergies and reactions) ______________________________

____

____

Doctors:

Primary Care Physician: ______________________________

Primary Care Physician's phone #: ______________________________

Specialist: ______________________________

Specialist's Phone #: ______________________________

Patient Social History (Circle):

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Rarely	Moderate	Daily	
Use of Drugs:	Never	Type/Frequency: ______________________			

Family Medical History:

	Age	Disease	Cause of Death
Father	______	______	______
		______	
Mother	______	______	______
		______	
Siblings	______	______	______
	______	______	______
	______	______	______
	______	______	______
	______	______	______
Children	______	______	______
	______	______	______
	______	______	______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________

Signature of the Patient, Parent or Guardian Date

Reviewing Provider:

______________________________ ______________

Signature of Provider Date

____

Printed Name of Provider

GULFCOAST HEALTHCARE GROUP

HIPAA OMNIBUS RULE

Authorization of Disclosure of Health Information

Patient Name: ______________________________ Date of Birth: ____________

Address: ______________________________ Phone: ______________

City: ____________________ State: __________ Zip: ____________

Member I.D.# ________________

I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

- Office Notes / Name of Physician ______________________________
- Radiology Reports ______________________________
- Laboratory Reports Date (s): ______________________________
- Other: ______________________________
- Paper Copy ____________________ Electronic Copy ____________________

The purpose of this request to release medical information is:

- Medical Care / Treatment ____ Insurance _____ Other (specify) _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time by submitting a request in writing to the office Compliance request.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. This office shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released. A copy of this signed form will be provided to me.
- The Office may charge an administrative fee to cover the cost of labor, copying and postage. The physician's office will inform me of any charges and arrange for payment.

This authorization expires ___/___ or if date not completed / one year after signed.

______________________________ DATE: ____________________

____________________ / ____________________

PRINT Name and Relationship to patient if minor or unable to sign. Retain this form in the patient's records

GULFCOAST HEALTHCARE GROUP

HIPAA OMNIBUS RULE

Patient Acknowledgement 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 acknowledgement & 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

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Consent for Purpose of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Provider" refers to Dr Larry D Johnson DC and/or Dr Aaron A Wohl MD.

I consent to the use or disclosure of my protected health information by Provider for the purpose of analyzing, operations of Provider. I understand that analysis, diagnosis or treatment of me by Provider may be conditioned upon my consent as evident by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Provider and understand that I have a right to view the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Provider. The Notice or Privacy Practices for Provider is also available in the waiting room at 2721 Del Prado Blvd S #250, Cape Coral, FL 33904. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the offices of Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date of Signing

Printed Name of Patient

FINANCIAL AND OFFICE POLICY

We believe that a clear definition of our financial and office policies will allow both you the patient and us the doctors to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH!

No treatment will be rendered until this policy has been read, understood and signed.

INSURANCE ASSIGNMENT POLICY

It is important that you realize in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such our patients must understand and agree to the following:

1. That you are considered a cash patient until your insurance can be verified.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance must be paid at the time of service. The co-payment must never exceed **$150.00** at any one time. Care will be suspended until said balance is taken care of.
5. That if your insurance company has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full of any outstanding balance.

CASH PATIENT POLICY

1. Payment is required for services on the day they are rendered.
2. The balance on your account can not exceed **$150.00** at any time during your course of treatment. If this occurs your course of treatment will have to be suspended until the balance is brought in line with this policy.
3. **All unpaid balances that have not had a payment received within sixty (60) days, will be collected through an outside agency.**

This **insurance** and **cash** policy must be followed and we ask that you sign this form as acknowledgment that our policy was explained to you, that you understand it and that you accept full responsibility.

Signature ____________________ Date ____________________

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TM-Flow Patient Profile

Today's Date:______________________________ Patient Signature: ______________________________

Name: ____ D.O.B ____________________________

Address: ____

City: _________________________________ State: ____________________ Zip: ___________________

Primary Phone: _______________________________________ Email: _____________________________

Insurance Policy#: ________________________________ Member ID# ___________________________

Height: ________________ Weight: ________________

Daily Activity Level: circle one

Very Light	Light	Moderate	Fitness Training	Athlete
stay at home, no activity	Office Activity	2-4 hours of exercise a week	2-4 hours a day	competitor

THE TEST IS CONTRAINDICATED IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

Y / N Patient undergoing external defibrillation.

Y / N Have an implantable pacemaker or cardiac device or insulin pump.

Y / N Bilateral mastectomy.

Y / N Dermatological lesions or calluses on the bottom of your feet.

Y / N An absence of two or more limbs.

Y / N Arterial catheters on arm or leg or an arteriovenous (AV) fistula or shunt.

TM Flow System
Patient Questionnaire

Patient Name:____

Date of Birth:______________________ Today's Date:________________

Please check the appropriate box if you are currently experiencing any of these symptoms, and/or if you have experienced them in the last 7 to 14 days.

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Frequent Urination	☐	☐
Fatigue (Tiredness)	☐	☐
Heartburn	☐	☐
Increased Hunger	☐	☐
Nausea	☐	☐
Numbness & Tingling in Hands or Feet	☐	☐
Vomiting	☐	☐

JDOMETER DYSFUNCTION (SUDOD)	Today	7-14 Days
Burning Sensation - Hands & Feet	☐	☐
Difficulty Digesting Food	☐	☐
Dizziness or Fainting	☐	☐
Exercise Intolerance	☐	☐
Sexual Difficulties	☐	☐
Sweat Abnormalities	☐	☐
Tingling Hands & Feet	☐	☐
Urinary Problems	☐	☐

ENDOTHELIAL DYSFUNCTION (ENDOD)	Today	7-14 Days
Angina (severe chest pain, often spreading to shoulder, arm, neck, back, or jaw)	☐	☐
Chest Pain that goes away with rest	☐	☐
Heartburn	☐	☐
Pain in Calves	☐	☐
Shortness of Breath	☐	☐
Stroke	☐	☐

CARDIOMETABOLIC RISK (CMR)	Today	7-14 Days
Headaches	☐	☐
:ziness	☐	☐
Swelling of Ankles	☐	☐

INSULIN RESISTANCE (IR)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Fatigue (Tiredness)	☐	☐
Increased Hunger	☐	☐

SMALL FIBER SENSORY NEUROPATHY (SFN)	Today	7-14 Days
Burning Sensation - Feet	☐	☐
Painful Contact w/ Socks/Bed Sheets	☐	☐
Pebble or Sand Like Sensation In Shoes	☐	☐
Stabbing or Electrical Shock Sensation	☐	☐
Pins and Needles Sensation in Feet	☐	☐

CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)	Today	7-14 Days
Blurred Vision	☐	☐
Cold, Clammy, Pale Skin	☐	☐
Depression	☐	☐
Dizziness or Lightheadedness	☐	☐
Thirst	☐	☐
Fainting	☐	☐
Fatigue (Tiredness)	☐	☐
Lack of Concentration	☐	☐
Lack of Energy	☐	☐
Nausea	☐	☐
Rapid, Shallow Breathing	☐	☐

PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)	Today	7-14 Days
Blood Clot In a Vein (Venous Thrombosis)	☐	☐
Irregular Heartbeat, too fast/slow (Atrial Fibrillation)	☐	☐

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RST SANEXAS Consent Form

Patient Name: ______________________________________ Date: ____________________

The following treatment plan has been explained to me in general terms, and I understand that:

1. The diagnosis requiring this procedure is: ____
2. The nature of this procedure is a vitamin blend mixed with normal Saline and 2% Lidocaine, injected subcutaneously to patient's specific area of pain. Injection area: ____
3. The purpose of this procedure is: The subcutaneous vitamin blend injections combined with RST Sanexas electric cell stimulation will decrease pain, as well as stimulate the verve tissue to regrow and create new axons. Stronger nerves will then allow for increased healing and reduced pain.
4. Material risk of this procedure: As a result of this procedure being performed, there may be a risk of infection, allergic reaction, scars, bleeding, and/or pain at the site of injection, vasovagal reaction, and extremely rare circumstances, seizure, cardiac arrest of death.
5. Practical alternatives to this procedure include Modalities and therapy.
6. If I choose not to have this procedure performed, my prognosis is UNKNOWN.
7. I also understand that this consent form will apply to all sessions of treatment. I understand I should have this treatment performed 2 to 3 times per week as recommended.

I understand that the Physician, Nurse Practitioner, Nurse and/or other medical personnel will rely on statements about my medical history and other corresponding records pertaining to my conditions to determine whether to perform the above procedure which has been explained to me and is recommended as a course of treatment for my condition.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES have been made to me concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary to perform other procedures which are unforeseen, or not known to be needed at the time of this signed consent/authorized the Physician, Nurse Practitioner and/or Nurse, herein to make the decision concerning such procedure, if additional procedures are deemed necessary or appropriate.

I also consent to the diagnostic studies test, local anesthesia, x-rays examinations and any other course of treatment related to the diagnosis or procedure explained herein. Too, I consent to the taking of photographs and/or the use of video recording equipment during the procedure for the purpose of medical education.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AN/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAN ITS CONTENT AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

I voluntarily consent to allow any Physician, Nurse Practitioner and/or Nurse, designated at this clinic, and all medical personnel under the provider's direct supervision to be involved in performing such procedures described or otherwise referred to herein.

______________________________ ______________________________

Signature of Patient | Signature of Physician//Nurse Practitioner/Nurse