# Patient Demographic Form

Name: ________________________________________________ Today's Date: ___/___/___

Date of Birth: ___/___/___ Age: ____ Sex: M F (circle one) Marital Status: S M D W # Children ___

Address: __________________________________ City: ____________ State: ___ Zip: ________

Home Phone #: (____)____________ Work #: (____)____________ ext ____ Cell #: (___)____________

Occupation: ___________________________________ Employer: ________________________

Email: ________________________________________________________________________

Social Security #: ____________________ Driver's License #: ___________________ State: ____

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Insured's Name: _____________________ Phone #: (____)__________ Insured's D.O.B. : ___/___/___

Insured's Address: ___________________________ Patient's Relationship to Insured: ___________

Insurance Company: ______________________________________ Telephone: (____)___________

Plan Name: _________________ Policy #: __________________ Group #: __________________

Group Name: __________________________ Insurance Type: PPO POS EPO HMO Traditional

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Emergency Contact: ______________________________________________________________

Relationship to Patient: ______________ Emergency Contact #: ______________________________

Signature of Responsible Party: ____________________________________ Date: ______________

Print Name: _____________________________________________________________________


North Jersey Whole Health Center, LLC
546 Broad Avenue, Englewood, NJ 07631 • Phone: (201) 569-1444

Robert Press, MS, DC
NJ Lic.#: 38MC00695500

# Assignment of Benefits

I, the undersigned, irrevocably assign to the below named healthcare professionals, my care providers, all the rights and benefits under my insurance contract for payments and services rendered to me.

I irrevocably authorize all information regarding by benefits under my insurance policy relating to any claims by the below named healthcare professionals to be released to the same.

I irrevocably authorize the below named health care professionals to file insurance claims on my behalf for services rendered to me in the course of care, and this specifically includes filing arbitration/litigation in my name on my behalf against the health care carrier/PIP carrier. I irrevocably direct that all such payments go directly to North Jersey Whole Health Center, LLC.

I irrevocably authorize the below named health care professionals to act on my behalf. I consent to their acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the benefit denial process set forth in the NJ Administrative Code and report any suspected violations of proper claims practices to the proper regulatory authorities.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or any assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Initial: ______

Any services that are not covered by your insurance is your responsibility and will be due and payable upon receipt of a billing statement. If correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of the charges incurred. If you do not have medical insurance, financial arrangements may be made.

If you understand and accept the foregoing, please sign on the line provided below:

Signed: ______________________________________________ Date: ______________

Print Name: ______________________________________________________________

Name of Minor Child (if applicable): ____________________________________________

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# Patient Consent For Treatment

I, the undersigned, voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending chiropractic physician, and it is the responsibility of any staff in the employment of said physician to carry out any instructions or orders given appertaining to my care.

Initial: ______

I understand that there are potential risks associated with treatment and diagnostic procedures and that to the greatest extent reasonable, those risks that are relevant to my condition will be disclosed to me prior to the performance of those procedures.

Initial: ______

I further understand that if I fail to disclose to the treating physician or his/her staff, any details of my medical history, including but not limited to prior treatments, surgeries, medications, previous adverse events, pregnancies, etc., that I am solely responsible for any unwanted or adverse outcomes that may result from said diagnostic procedures or treatments.

Initial: ______

Furthermore, I understand that it is my responsibility to disclose to my treating physician or his/her staff, any ongoing or new/recent medical history, in order for him/her to determine the suitability of any treatments that I am or will be receiving.

Initial: ______

If you understand and accept the foregoing, please sign on the line provided below:

Signed: ______________________________________________ Date: ______________

Print Name: ____________________________________________________________

Name of Minor Child (if applicable): ____________________________________________

# HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization for Patient: _______________________________________(print patient name)
I authorize the below named healthcare providers to use and disclose the protected health information described below to the above named patient's health or auto insurance company (3rd party payor), other healthcare professional for the purpose of referral or co-management of the above named patient's health condition, or other individual(s):

(individual seeking the information).________________________________________________________

2. Effective Period:
This authorization for release of information covers the period of healthcare from:

a. ☐ _____________ to _____________.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization:
I authorize the release of the above named patient's complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect from the initiation of care until:

**(CIRCLE ONE)**

Indefinitely, until revoked in writing OR Discharge from care OR __________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that the above named patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, though I understand that if I refuse to sign this agreement and wish for care of the above named patient to proceed, that I will be financially responsible for the care received by the patient, as the healthcare provider will be unable to obtain payment from the patient's insurance company without a release of health information.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| Signature of patient, parent/guardian or personal representative | Printed name of patient, parent/guardian or personal representative, and his/her relationship to patient | Date |

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# Patient Consent For Use and Disclosure of PHI

I, the undersigned, give my consent to the provider, it's agents and assigns to: (i) use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations; (ii) release my entire medical record to any other provider or its employees upon a representation that the provider will use the information for treatment or payment; (iii) disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number; (iv) call and leave a voice mail message at my home or other number that I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations; (v) discuss my PHI with: (a) any person that accompanies me to a visit or procedure or is present with me when the provider is present, and (b) any person that identifies himself or herself as active in my mental, physical, emotional or spiritual care, including but not limited to family, close personal friends, clergy and patient advocates.

**Assignment of Benefits:** I hereby authorize any insurance benefits be paid directly to the physical and I understand that I am responsible for non-covered services. I also authorize the treating provider to release any information required in the processing of the claim. I also assign my rights to bring claims for lack of payment, to the below named healthcare provider(s).

If you understand and accept the foregoing, please sign on the line provided below:

Signed: ______________________________ Date: ______________

Print Name: ________________________________________

Name of Minor Child (if applicable): ____________________________

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# HIPAA Release Form

I, the undersigned, being of full age, do hereby consent pursuant to the security requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) to allow the below named healthcare professionals to transmit my records, or the records of a minor child of whom I am the parent, guardian, or legally appointed representative by fax, email, or any other electronic means at their discretion, and as they see fit, to obtain reimbursement from my insurance carrier, from me, or to communicate with my attorney, carrier, or other party as required for the administration of my or the aforementioned minor child's affairs. Furthermore, I give the below named healthcare professionals permission to post my name in their office as a source of referrals, with my written consent.

To my carrier: You may release any information regarding my or the aforementioned minor child's records to the below named healthcare professionals and clinic, and I herewith demand a copy of any independent examination reports automatically be forwarded to them, for which I accept responsibility for any reasonable charge applicable thereto, pursuant to law.

If you understand and accept the foregoing, please sign on the line provided below:

Signed: ______________________________ Date: ______________

Print Name: ______________________________________

Name of Minor Child (if applicable): ___________________________

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# Payment Policy

Thank you for choosing us as your chiropractic provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative chiropractic care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

____________________________________ _______________

**Signature of patient or responsible party** **Date**

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# Case History and Review of Systems

Patient Name: __________________________________________ Date: ____________________

## Please Check Only The Boxes That Apply

| **General** | **Cardiovascular Continued** | **Gastrointestinal Continued** | **Musculoskeletal Continued** | **Endocrine Continued** |
|---|---|---|---|---|
| Lethargy/Weakness | Palpitations | Difficulty swallowing | Fractures | Excessive sweating |
| Fever / Chills | Swelling in hands or feet | Jaundice | Implants/Plates/Screws/Pins | Heat/Cold intolerance |
| Recent weight loss or gain | High blood pressure | Liver disease | Hip problems | Weight gain/loss |
| Dizziness | High cholesterol or triglycerides | Gallbladder problems | Knee problems | Frequent urination |
| Other: | Heart murmur | Pancreatitis | Foot/Ankle problems | Excessive thirst |
| | Blood clots | Change in bowel habits | Shoulder problems | Change in appetite |
| **Head, Eyes, Ears, Nose, Throat** | Pacemaker | Black or bloody stool | Elbow/Wrist problems | Hair changes |
| Headaches | Mitral valve prolapse | Colon cancer or colon polyps | Poor posture | Hyperthyroidism |
| Eye or vision problems | Congenital heart defects | Food sensitivities | Gout | Hormonal or glandular problems |
| Eyeglasses or contact lenses | Rheumatic fever | Irritable bowel syndrome | Other: | Hyperparathyroidism |
| Nosebleeds | Leg pain upon walking | Crohn's / Ulcerative Colitis | | Testosterone deficiency |
| Eye surgery | Varicose veins | Gastric reflux | **Blood / Lymphatic** | Cushing's syndrome |
| Cataracts | Dizziness | Other: | Anemia | Other: |
| Glaucoma | Excessive bruising | | Bleeding | |
| Sore throat | Coronary artery disease | **Neurological** | Blood clots | **Genitourinary** |
| Hoarseness | Other: | Frequent headaches | Past transfusions | Painful or frequent urination |
| Swollen glands | | Migraines | Leukemia / Lymphoma | Incontinence |
| Nose congestion or sinus trouble | **Respiratory** | Dizziness | HIV / AIDS | Hesitancy / Urgency |
| Ear or hearing problems | Persistent cough | Fainting | Sickle cell | Blood in urine |
| Dental problems | Spitting up blood | Memory loss | Other: | Kidney stones |
| Gum problems | Asthma or wheezing | Poor balance | | Urinary infections |
| TMJ problems | Exercise intolerance | Numbness / Tingling | **Allergies** | Genital or bladder problems |
| Post-nasal drip | Sleep apnea | Epilepsy or seizures | Seasonal | Sexually transmitted disease |
| Other: | Emphysema | Stroke | Medication | Loss of libido |
| | Snoring Issues | Tremors | Food | Other: |
| **Skin/Hair** | Tuberculosis | Head injury | Other: | |
| Skin trouble or rashes | Pneumonia | Anxiety / Panic disorder | | **Male Only** |
| Flushing | Hay fever | Depression | **Psychiatric** | Dribbling |
| Excessive acne | Other: | Sleeping problems | Alzheimer's disease | Erectile difficulty |
| Eczema | | Weak muscles | Insomnia | Testicular pain or lumps |
| Psoriasis | **Gastrointestinal** | Loss of sense of smell or taste | Difficulty concentrating | Prostate disease |
| Skin cancer | Loss of appetite | Difficulty concentrating | Memory loss/confusion | Penile discharge |
| Skin pigmentation issues | Nausea or vomiting | Other: | Depression | Other: |
| Change in hair/nails | Diarrhea | | Anxiety | |
| Easy bruising | Constipation | **Musculoskeletal** | Agitation/Irritability | **Female Only** |
| Gum bleeding | Abdominal pain | Arthritis | Suicidal thoughts | Painful sex |
| Other: | Stomach ulcer | Joint pain or swelling | Chemical dependency | Vaginal disharge |
| | Bloating/Cramping | Neck / Back pain | Other: | Breast pain or lumps |
| **Cardiovascular** | Heartburn | Traumatic injuries | | Hot flashes |
| Chest pain or tightness | Hemorrhoids | Osteoporosis | **Endocrine** | Menstrual irregularity |
| Heart attack | Hepatitis | Scoliosis | Diabetes | Menopause |
| Shortness of breath | Cirrhosis | Cramping | Thyroid problems | Other: |

## Case History and Review of Systems

**May we contact your primary care doctor regarding your treatment?** Yes No

Primary care doctor name and phone number: ______________________________

Hospitalizations:

Surgeries:

Prior Accidents/Injuries:

Ongoing Illness:

Allergies:

Current Medications:

Nutritional Supplements / Vitamins:

Family History:

Past Medical Procedures:

Past Chiropractic Care:

**Lifestyle: (Circle One)**

Tobacco Use: Never Used Previously Used 1-2 packs/day 2 or more packs/day

Alcohol Use: Abstain Light/social Heavy Recovering alcoholic Binge drinker

Activity Level: Sedentary Light Activity Moderate Activity Vigorous Activity

# Case History Form

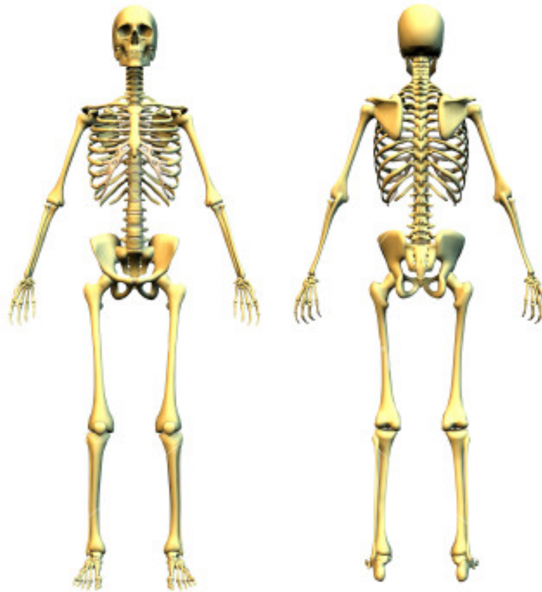
Date:___/___/______ Patient Name:____________________________

## Pain Chart

**Please mark areas affected on this diagram, using the following abbreviations:**

**P**=Pain
**N**=Numbness
**T**=Tingling

**S**=Soreness
**A**=Ache
**St**=Stiffness(ST)



Front Back

**Severity of symptoms: (Circle a number 0 - no pain through 10 - most pain imaginable)**

| | | | |
|---|---|---|---|
| Headaches: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Shoulder Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Dizziness: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Shoulder Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Nausea: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Arm Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Anxiety: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Arm Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Neck Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Forearm Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Upper Back Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Forearm Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Mid Back Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Wrist Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Lower Back Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Wrist Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Pelvic Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Hand Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Tailbone Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Hand Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Chest Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Buttock Pain | 0 1 2 3 4 5 6 7 8 9 10 |
| Abdominal Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Buttock Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Genital Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Rt. Thigh Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| | | Lt. Thigh Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Rt. Knee Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Knee Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Rt. Leg Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Leg Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Rt. Ankle Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Ankle Pain: | 0 1 2 3 4 5 6 7 8 9 10 |
| Rt. Foot Pain: | 0 1 2 3 4 5 6 7 8 9 10 | Lt. Foot Pain: | 0 1 2 3 4 5 6 7 8 9 10 |

I hereby attest that the foregoing information is true and correct to the best of my knowledge, and that I have not knowingly omitted any prescription, street, or over the counter medication, supplements, or vitamins from this case history form.

**Patient Signature**: ____________________________________________ **Date:** ______________________________