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: ____

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): ____

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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 Form

(Please fill out both sides)

Date:___/___/______ Patient Name:______________________________

GENERAL
1______ Fever
2______ Chills
3______ Night Sweats
4______ Loss of Sleep
5______ Fatigue
6______ Nervousness
7______ Weight Loss or Gain
8______ Allergies
9______ Bleeding Problem
10_____ Anemia
11_____ Diabetes
12_____ Cancer
13_____ Heart Disease
14_____ Asthma
15_____ HIV Risk Factors
(Sharing needles, etc...)

EYE, EAR, NOSE and THROAT
16_____ Poor Vision
17_____ Pain in Eye(s)
18_____ Deafness/Difficulty Hearing
19_____ Nosebleeds
20_____ Nose Problems
21_____ Sinus Trouble
22_____ Dental Problems
23_____ Hoarseness
24_____ Tonsillectomy

GASTROINTESTINAL
25_____ Poor Appetite
26_____ Poor Digestion
27_____ Difficulty Swallowing
28_____ Belching or Gas
29_____ Frequent Nausea
30_____ Vomiting
21_____ Vomiting Blood
32_____ Pain over Abdomen
33_____ Ulcer
34_____ Black or Bloody Stool
35_____ Liver Problems
36_____ Gall Bladder Problems
37_____ Jaundice
38_____ Hernia
39_____ Diarrhea
40_____ Constipation
41_____ Hemorrhoids
42_____ Appendicitis

RESPIRATORY
53_____ Difficulty Breathing
54_____ Chronic Cough
55_____ Spitting Blood
56_____ Spitting Phlegm
57_____ Wheezing
58_____ Pneumonia
59_____ Tuberculosis

CARDIOVASCULAR
60_____ Irregular Heartbeat
61_____ High Blood Pressure
62_____ Pain over Heart
63_____ Previous Heart Trouble

CARDIOVASCULAR CONT.
64_____ Ankle Swelling
65_____ Varicose Veins
66_____ Rheumatic Fever
67_____ Stroke

GENITOURINARY
68_____ Frequent Urination
69_____ Painful Urination
70_____ Blood in Urine
71_____ Kidney Disease
72_____ Urinary Infection
73_____ Inability to Control Urination
74_____ Difficulty Starting Urine Flow
75 Get up ___ times per night to urinate
76_____ Venereal Infection (STD)
77_____ Sexual Difficulties

SKIN
78_____ Itching
79_____ Bruising
80_____ Change in Mole(s)
81_____ Skin Cancer
82_____ Eczema
83_____ Psoriasis
84_____ Other Skin Lesions

NEUROLOGICAL
85_____ Weakness
86_____ Twitching
87_____ Tremors
88_____ Headache
89_____ Fainting
90_____ Dizziness
91_____ Convulsions
92_____ Epilepsy
93_____ Numbness/Tingling
94_____ Arm/Leg Pain
95_____ Mental Disorder

ENDOCRINE
96_____ Goiter
97_____ Thyroid Cancer
98_____ Adrenal Disease
99_____ Diabetes (Indicate type I or II)

ACCIDENTS/TRAUMA
100___ Motor Vehicle Accidents
101___ Other Trauma/Accidents

WOMEN ONLY
102___ Live Births
103___ Miscarriages
104___ Painful Periods
105___ Excessive Flow
106___ Irregular Cycles
107___ Vaginal Burning/Itching
108___ Hot Flashes
109 Date Last Period Began __________

MEN ONLY
110___ Testicular Swelling/Pain
111___ Prostate Problem

IMMUNE SYSTEM
112___ Auto Immune Disease
113___ Getting Sick Very Easily
114___ Leukemia/Lymphoma

MUSCULOSKELETAL
115___ Neck Stiffness/Pain
116___ Pain Between Shoulders
117___ Low Back Pain
118___ Swollen Joints
119___ Painful Joints
120___ Muscle Aches/Soreness
121___ Spinal Curvature
122___ Arthritis

CHILDHOOD DISEASES
123___ Mumps
124___ Measles
125___ Chickenpox

HOSPITALIZATIONS
126___ List Dates and Reasons:
____
____
____
____

SURGERIES
127___ List Dates and Reasons:
____
____
____

HABITS
128___ Smoking _____ packs/day
129___ Drinking
130___ Recreational Drug Use

FAMILY HISTORY
Use the following abbreviations:
M=Mother **F**=Father **S**=Sister **B**=Brother
MM=Mother's Mother **MF**=Mother's Father
FM=Father's Mother **FF**=Father's Father

131_______________ Diabetes
132 _______________Thyroid Dz
133_______________ Tuberculosis
134_______________ Kidney Dz
135_______________ High Blood Press.
136_______________ Heart Disease
137_______________ Muscle, Bone, or Nerve Disease
138_______________ Other

VACCINATIONS (Please use MM/YYYY)
________________________ Tetanus/DPT
________________________ Influenza
________________________ Pneumovax

PRIMARY CARE PHYSICIAN
Name and phone number
____
____

The items above may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave the space blank if you NEVER had the problem.

Case History Form

Date:___/___/_____ Patient Name:______________________

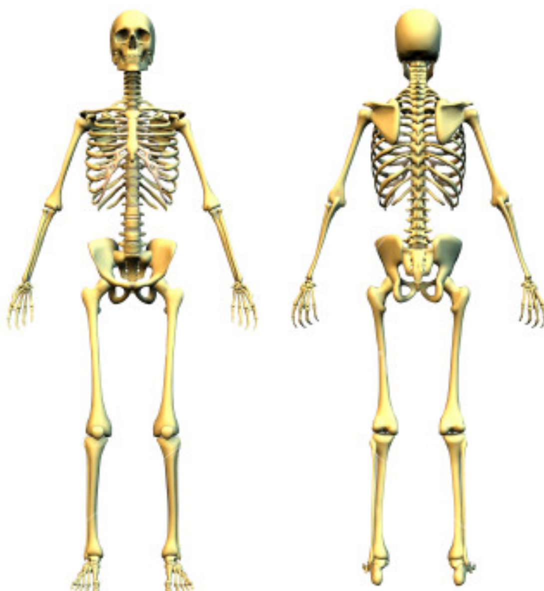
General Health ____
Childhood Illnesses ____
____
Major Adult Illnesses ____
Serious Injuries & Resulting Disability ____
Allergies ____
Recent Screening Tests ____
Primary Care Physician and Any Specialists Consulted ____
____

Medication List - Include over the counter medications
1. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
2. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
3. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
4. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
5. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
6. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
7. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
Others ____
____
____

Supplements/Vitamins/Herbs List
1. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
2. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
3. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
4. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
5. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
6. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
7. ____________________ Dosage ________ Frequency ________ Reason for taking ______________
Others ____
____
____

Known Allergies ____
____

Pain Chart



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

P=Pain
R=Radiation
N=Numbness
T=Tingling
S=Soreness
A=Ache
St=Stiffness(ST)

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:** ____________________