

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

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, or the minor child's of whom I am the parent, guardian, or legally appointed representative, protected health information ("PHI") to carry out treatment, payment, or health care operations, by fax, email, or other electronic means; (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) communicate with my attorney, insurance carrier, or other party as required for the administration of my or the aforementioned minor child's affairs; (iv) 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; (v) 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; (vi) 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.

I furthermore give the below named healthcare professionals permission to post my name in their office as a source of referrals, with my written consent.

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).

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): _____

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. At the office's discretion, the missed appointment fee may be waived, if there are extenuating circumstances including but not limited to severe weather events, legitimate personal or family emergency, or sudden illness.

The current missed appointment fee is \$40 for a missed appointment.

Initial Here _____

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

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 discharge
	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

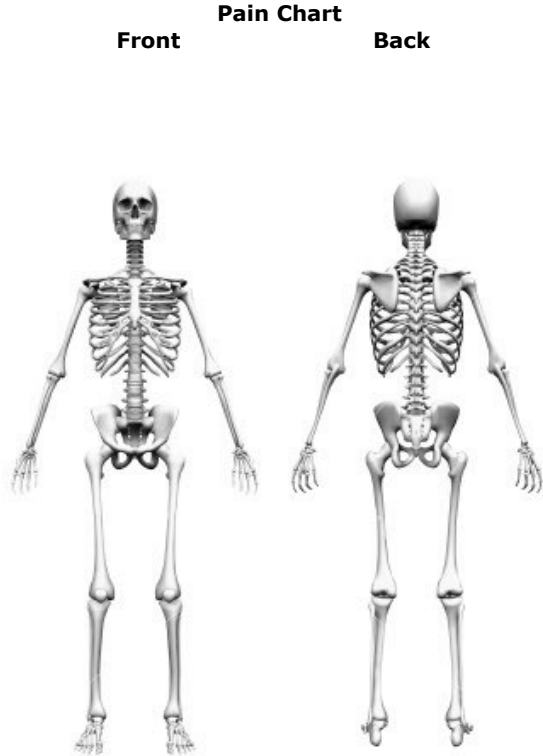
Alcohol Use: Abstain Light/social Heavy Recovering alcoholic Binge drinker

Activity Level: Sedentary Light Activity Moderate Activity Vigorous Activity

Case History Form

Date: ___/___/___

Patient Name: _____



Please shade in areas affected on this diagram.

4/10 pain = "I took some painkillers and went to work today, but it was distracting."

5/10 pain = "I went to work today, but the pain was so bad I left early to go to the doctor."

6/10 pain = "I can't even go into work with this much pain."

7/10 pain = "I think I need to go to the hospital."

8/10 pain = "I'm crying because it hurts so much and I'm going to the hospital."

Please only circle areas of pain/discomfort.

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

Headaches:	0	1	2	3	4	5	6	7	8	9	10
Dizziness:	0	1	2	3	4	5	6	7	8	9	10
Nausea:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10
Neck 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
Mid Back 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
Pelvic 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
Chest 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
Genital Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Hip 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
Rt. 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
Rt. 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

Rt. Shoulder Pain:	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
Rt. Arm Pain:	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
Rt. Forearm 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
Rt. Wrist 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
Rt. Hand 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
Rt. Buttock 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
Lt. Hip 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
Lt. Knee 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
Lt. Ankle 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

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