SPINE AND REHABILITATION CENTER OF MORRIS, LLC
210 Malapardis Road, Suite 203
Cedar Knolls, NJ 07927
Phone: (973) 359-4400
Fax: (973) 359-4414

BASIC PATIENT INFORMATION

Name: _____ **Date of birth:** ____/____/____

Address: _____ **City:** _____ **State:**_____ **Zip code:**_____

Home#:_____-_____-_____ **Cell#:**_____-_____-_____ **SSN#:**_____-_____-_____

Age: ____ **Birth Sex:** Male / Female **Race:** White/Black African American/Asian/American Indian Alaska Native/Hawaiian Pacific Islander/Decline **Ethnicity:** Latino / Not Latino / Decline

Preferred Language/s: _____ **Marital Status:** M S D W

Email:_____ **Occupation:**_____ **Employer:**_____

Employer Address: _____ **Phone#:** _____-_____-_____

Spouse: _____ **Employer:** _____ **Occupation:**_____

Emergency Contact: _____ **Phone#:**_____-_____-_____

Please circle which type of coverage that is applicable in this case:

Major Medical Insurance / Medicare / Worker's Comp / Auto Insurance / None

Primary Insurance name: _____ **Secondary Insurance name:** _____

How did you hear about our office? : _____

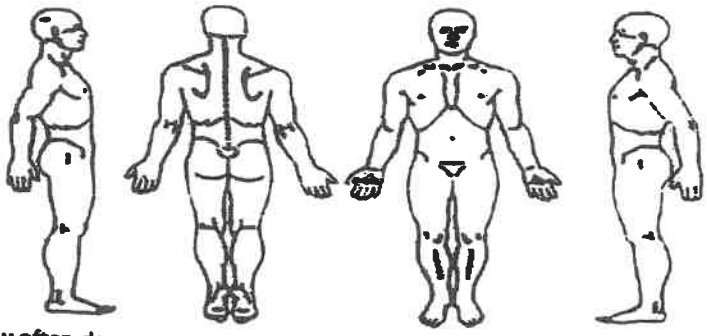
Patient Signature: _____ **Date:** ____/____/____

PATIENT INTAKE FORM

Patient Name: _____ Date: ____/____/____

Date of birth: ____/____/____ Height: ____'____" Weight: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)
   - ☐ Occasionally (26-50% of the time)
4. How would you describe the type of pain?
   - ☐ Sharp
   - ☐ Dull
   - ☐ Diffuse
   - ☐ Achy
   - ☐ Burning
   - ☐ Shooting
   - ☐ Stiff
   - ☐ Numb
   - ☐ Tingly
   - ☐ Sharp with motion
   - ☐ Shooting with motion
   - ☐ Stabbing with motion
   - ☐ Electric like with motion
   - ☐ Other: _____
5. How are your symptoms changing with time?
   - ☐ Getting worse
   - ☐ Staying the same
   - ☐ Getting better
6. Using a scale of 0-10 (10 being the worst), how would you rate your problem? (Please circle)

   0 1 2 3 4 5 6 7 8 9 10
7. How much has the problem interfered with your work?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. How much has the problem interfered with your social activities?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. Who else have you seen for your problem?
   - ☐ Chiropractor
   - ☐ ER physician
   - ☐ Massage therapist
   - ☐ Neurologist
   - ☐ Orthopedic
   - ☐ Physical therapist
   - ☐ Primary care physician
   - ☐ No one
   - ☐ Other: _____
10. How long have you had this problem? _____
11. How do you think your problem began? _____
12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No
13. What makes this problem better? _____
14. What aggravates your problem? _____
15. What concerns you the most about your problem; what does it prevent you from doing?

_____

Occupation: _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

PAST	PRESENT	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper back Pain
☐	☐	Mid back Pain
☐	☐	Low back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip Pain
☐	☐	Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Pain/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Drug/Alcohol Dependency

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pain
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Loss
☐	☐	Ulcers
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	General Ffatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness
☐	☐	Chronic Sinusitis

PAST	PRESENT	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systematic Lupus
☐	☐	Epilepsy
☐	☐	HIV/AIDS
☐	☐	Other: _____

For Females Only:

☐	☐	Hormonal Replacement
☐	☐	Birth Control Pills
☐	☐	Pregnancy

20. List all prescription medications you are currently taking:

_____

21. List all over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ Computer work:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐ No ☐ Yes If yes, why? _____

26. Have you had significant past trauma? ☐ No ☐ Yes If yes, what? _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ Date: ____/____/____

PATIENT OFFICE AGREEMENT

INSURANCE:
As a courtesy to our patients, we will verify your benefits and file insurance claims on your behalf to the carrier(s) that you have provided our office. However, if your insurance changes or terminates throughout your care, we ask that as a courtesy you provide us with updated and current information as soon as possible.

INSURANCE PAID TO PATIENT (BCBS PT's only):
As a non-participating provider, Horizon Blue Cross & Blue Shield will send the insurance payments directly to you in the name of insured or subscriber. You understand that it is your responsibility to endorse or remit your payment within 14 calendar days.

FINANCIAL RESPONSIBILITY:
Patient deductibles, co-insurances and/or the agreed office payment(s) are due prior to services being received. For your convenience we accept cash, personal check, Visa, MasterCard and Discover as forms of payment.
Returned check(s) fee is $30.00

AUTO ACCIDENT PATIENTS:
Patients who have elected to not use their health insurance to serve as their secondary coverage, will be responsible for the 20% Co-Pay for each visit in addition to the selected plan's deductible. Should you be represented by an attorney, the financials responsibility will come out of the case's settlement, if any. If for any reason, the case is dropped by the representing attorney or there is no settlement, the patient is fully responsible for the plan's deductible and 20% Co-Payment.

LEGAL FEES:
I understand and agree that should it become necessary for my account to be sent out to a third party collection, such as an attorney or agency for collection or suit, I will be responsible to pay for all reasonable attorney fees and collection costs.

SUPPLIES AND EQUIPEMENT:
I understand and agree that should my insurance company not cover the provided supply(s) or equipment, I am responsible to pay for the supply and/or return the supply(s) or equipment within 7 days of being advised of the same. Should I fail to do the same, I will be financially responsible.

ASSIGNMENT OF INSURNACE BENEFITS:
I understand that I will be assigning my medical benefits to this clinic. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Spine and Rehabilitation Center of Morris LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by the insurance(s).

AUTHORIZATION FOR TREATMENT:
I hereby authorize and consent to the administration of any medical, diagnostic or therapeutic treatment, as may be deemed medically necessary or advisable. I have the right to refuse consent, to any proposed procedure or therapeutic course. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CERTIFICATION:
I hereby certify that I have read each of the above statements, have had each explained to me to my satisfaction, and have been offered a copy of this patient agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this patient agreement. A photocopy of this document has the same effect has an original.

PATIENT SIGNATURE	RELATIONSHIP TO PATIENT	DATE SIGNED
PATIENT NAME-PLEASE PRINT	WITNESS SIGNATURE	DATE SIGNED

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OFFICE POLICY REGARDING INSURANCE CHECKS

Dear Patients:

This letter is to inform you that you may be directly receiving checks from your insurance carrier for the treatments that you have received in our office. It is your responsibility that you forward these checks and any correspondence that is included into our office. In the event that you withhold and cash the checks you are ultimately responsible for the amount, as well as any balance of your account.

By signing this letter you agree and acknowledge to all terms stated above.

_____
Print Name

_____
Signature

_____
Date

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HIPAA HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made to submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent needs to only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment or health care operations, the physicians and therapists have the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature _____ Date _____