ACCOUNT # TODAY'S DATE

PATIENT INFORMATION

PATIENT NAME SOC SEC #

ADDRESS

PHONE DATE OF BIRTH

MARITAL STATUS: SINGLE MARRIED OTHER

EMPLOYER/SCHOOL PHONE

ADDRESS

OCCUPATION

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST SO SHE CAN MAKE A COPY

COMPANY NAME PHONE

ADDRESS

POLICY# GROUP#

PLEASE INFORM RECEPTIONIST IF YOU HAVE ANY ADDITONAL COVERAGE

POLICY HOLDER INFORMATION

NAME SOC SEC #

EMPLOYER NAME PHONE

ADDRESS DATE OF BIRTH

RELATIONSHIP TO PATIENT SELF PARENT OTHER

INJURY INFORMATION

IS YOUR INJURY: WORK RELATED AUTO RELATED SCHOOL RELATED OTHER

DATE OF YOUR INJURY

IF WORK OR AUTO RELATED, PLEASE COMPLETE NEXT LINE

CLAIM # ADJUSTOR NAME

REFERRING DOCTOR INFORMATION

DOCTOR NAME PHONE

ADDRESS

PLEASE TURN OVER TO READ AND SIGN THE BACK OF THIS PAGE

** There is a $25 fee for appointments cancelled without a 24 hour notice **

Thank you for choosing New Jersey Spine and Sports Medicine, P.C. for your medical needs. The following is our office procedure regarding payment for services rendered.

Payment is due at the time services are rendered, unless other arrangements have been made. We accept payment in the form of Visa, Master Card, check or cash.

The patient, or guardian if the patient is under the age of 18, is personally responsible for payment after services are rendered. This office will make special arrangements to collect balances due from Third Party Payors under the following circumstances. However, you will still remain personally responsible:

Auto Accidents

Invoices will be submitted to your auto carrier, then to your health insurance provider, if applicable. You are responsible for providing this office with the name, address, and phone number of your auto insurance carrier, and your claim number. If you do not provide this office with that information within one week of your initial visit, you will be responsible for the entire balance due.

Workers Compensation

Invoices will be submitted to your workers comp carrier once you supply us with the name, address, and phone number of your workers comp carrier, and your claim number. If you do not provide this office with that information within one week of your initial visit, you will be responsible for the entire balance due. It is the patient's responsibility to obtain authorization to be treated by this office. If authorization is not obtained, you will be responsible for the entire balance.

School Injuries

This office will submit the invoice to the patient's health insurance provider, if applicable, then to the school insurance carrier. It is the patient's responsibility to supply this office with a school insurance form within one week of your first treatment. If we do not have the school insurance form on file, the patient/guardian will be responsible for the remaining balance due.

HMO Claims

It is the responsibility of the patient to obtain a referral from their PCP/Specialist before services are rendered. It is also the responsibility of the patient to keep a record of how many visits were authorized and used. If you do not have the referral at the time of visit, you will be responsible for payment of the balance due. If you provide this office with a referral, you will be responsible for your copayment amount at the time of the visit.

Please sign below after you have read the above policies. By signing below you take responsibility for payment of all medical bills incurred in this office, and authorize this office to treat you. If you are under the age of 18, please have your guardian sign below.

Signature: ______________________________

Date: ______________________

** There is a $25 fee for appointments cancelled without a 24 hour notice **

84 Orient Way
Rutherford, NJ 07070
Phone: (201) 964-0200
Fax (201) 964-0220

New Jersey Spine and Sports Medicine PC

Dean T. Filion, D.O. Robert D. Brady. D.O.

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our "Notice of Privacy Practices". Our full length "Notice of Privacy Practices" is available upon request.

Date of last revision: 4/11/03
Effective Date: Immediately

This information is made available on request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- To run our Practice more efficiently and ensure all our patients receive quality care
- Required by law
- To avert a serious threat to health or safety
- For research
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes
- For appointment and patient recall reminder
- In emergency situations

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed "Notice of Privacy Practices", which is available upon request.

Signature of Patient

Date

INFORMATION REQUIRED UNDER OBAMA CARE

PLEASE PRINT

DATE: DATE OF BIRTH:

PATIENT NAME:

PREFERRED LANGUAGE:

RACE: **(PLEASE CIRCLE ONE BELOW)**

CAUCASIAN, HISPANIC, ASIAN, AFRICAN AMERICAN
AMERICAN INDIAN, ASIAN, NATIVE HAWAIIAN OR
OTHER PACIFIC ISLAND, WHITE, OTHER

ETHNICITY: **(PLEASE CIRCLE ONE BELOW)**

HISPANIC OF LATINO OR NOT HISPANIC OR LATINO

CHIEF COMPLAINT:

CURRENT MEDICATIONS:

KNOWN ALLERGIES TO MEDICATION:

HEIGHT:

WEIGHT:

BLOOD PRESSURE:

ARE YOU A SMOKER? YES NO

New Jersey Spine & Sports Medicine, PC

Date of Evaluation ___/___/___

Name (first/middle initial/last) ______________________ Age _____ D.O.B. ___/___/___

Referring Physician ______________________ Family Physician ______________________

Occupation ______________________ Work related? ☐ Yes ☐ No Auto related? ☐ Yes, State _____ ☐ No

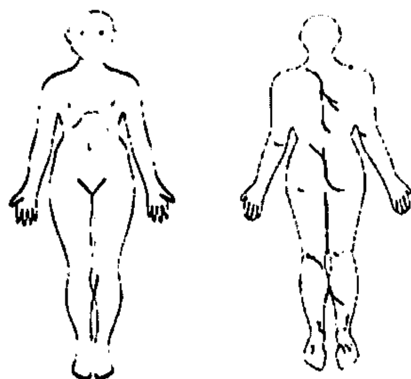
Leisure Activities ______________________

How did you hear about us? ☐ Physician ☐ Family ☐ Friend ☐ Radio ☐ Advertisement ☐ Other __________

1. What problems or concerns would you like addressed? Explain: ______________________

____

2. When did your problem develop? (exact date) ___/___/___
3. How did your problem begin? ______________________
4. Since your problem began, is it? ☐ Improving ☐ Staying the same ☐ Worsening
5. Please note on the diagram where you're experiencing pain (using the appropriate letters):



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning
R = Radiating
A = Ache

6. Is your pain?

☐ Constant ☐ Intermittent

7. Express your pain on a scale of 0-10 (10 being extreme):

_____ At present _____ At best _____ At worst

8. Are there any activities or positions that significantly <u>worsen</u> your symptoms?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Lying down ☐ Ice ☐ Heat ☐ Coughing/Sneezing

☐ Bending ☐ Bowel or bladder movements ☐ Other ______________________

9. Are there any activities or positions that significantly <u>improve</u> your symptoms?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Lying down ☐ Ice ☐ Heat ☐ Pain medications

☐ Bending ☐ Other ______________________

10. What part of the day do you feel best? ______________________ Worst? ______________________
11. Is sleep disturbed due to your pain? ☐ Yes ☐ No

(over)

12. Are you currently receiving the following treatment with another provider?

☐ Physical Therapy ☐ Chiropractic ☐ Massage ☐ Home Healthcare Services ☐ Skilled Nursing Facility Services

13. Have you had prior treatment(s) for this condition?

☐ Physical Therapy ☐ Chiropractic ☐ Injections ☐ Massage ☐ Surgery ☐ Acupuncture ☐ Other__________

14. Recent diagnostic tests? ☐ X-ray ☐ CT Scan ☐ MRI ☐ EMG ☐ Bone Scan ☐ Other____________________

15. Please list all medications you are currently taking: ____

____

16. Have you <u>ever</u> had any of the following? (Please check all that apply.)

☐ Anxiety disorder	☐ Depression	☐ Heart problems /Heart attack	☐ Nausea	☐ Smoking ☐ past ☐ present
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Strokes
☐ Bladder problems	☐ Dizziness	☐ High blood pressure	☐ Pacemaker	☐ Sweating
☐ Blood clots	☐ Easy bleeding	☐ HIV/AIDS	☐ Pregnancy ☐ past ☐ present	☐ Ulcers
☐ Bowel problems	☐ Emphysema	☐ Kidney problems	☐ Rheumatoid	☐ Vomiting
☐ Broken bones	☐ Fatigue	☐ Liver/Gallbladder	☐ Ringing in ears	☐ Weakness
☐ Cancer	☐ Fever	☐ Major trauma	☐ Seizures	☐ Weight gain
☐ Chills	☐ Head Injury	☐ Metal Implants	☐ Skin problems	☐ Weight loss
☐ Circulatory problems	☐ Headaches			

Please explain any checked items above and add others not listed: ______________________________

____

____

17. Past surgical history: ____

____

DX1 ________________ DX2 ________________ DX3 ________________