New Patient Intake Form

Coastal Spine and Rehabilitation Center
800 Highway 71
Sea Girt, NJ 08750

PATIENT INFORMATION (Please print)

Patient Name:		**Date of Birth:**	**Age:**
Address:	**City:**	**State**	**Zip**
Phone:	**Work:**	**Cell:**	
Cell Carrier: **Text or Email Appointment Reminder: Y/N**		**Email**	
Social Security Number	**Sex:** **Male Female**	**Marital Status:** **Single Married Divorced Widowed**	
Primary Care Physician:	**Phone:**		
Occupation:	**Employer & Telephone Number:**		
Emergency Contact & Relationship:	**Phone:**		
Website referral or who referred you?			

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance Company	**HSA Acct:** **Y / N**
Address	
Policy #	**Group #**
Subscriber Name	**D.O.B**
Subscriber SS #	

SECONDARY INSURANCE

Name of Insurance Company	
Address	
Policy #	**Policy #**
Subscriber Name	**Subscriber Name**
Subscriber SS #	

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Sea Girt Spine and Rehabilitation for any services furnished me by the physician. I authorize any holder of medical information about me to be released to the Center of Medicare and Medicaid services and its agents any information to determine these benefits payable for related services.

_____

Patient Signature **Date**

I, undersigned, authorize payment of medical benefits to Sea Girt Spine and Rehabilitation for any service furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company or their agent, information concerning health care, treatment, or supply provided to me. This information will be used for purpose of evaluating and administering claims benefits.

_____

Patient Signature **Date**

Name:_____ Date:_____

Patient Information – Page 2

List of chief complaints in order of severity:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Where is the pain? _____
Does the pain travel? Yes No
If yes, where? _____

What is the severity of your problem?

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

How are your symptoms affecting your lifestyle? (i.e. job, relationships, recreational activities, household chores)

_____

Circle any activities that *aggravate* the condition:

Walking Lifting Coughing Sitting Bending Sneezing Sleeping Other

Circle any activities that *alleviate* the condition:

Rest Standing Heat Exercise Lying Down Ice Sitting Massage Other

Do you currently have, or have you had any of the following condition or symptoms?

__Headaches
__Knee pain
__High Blood Pressure
__Shortness of Breath
__Loss of smell/taste
__Numbness or tingling
__Hip pain
__Fatigue
__Vertigo
__Wrist of hand pain
__Chest pain
__Heart condition
__Stomach problems
__Ringing in ears
__Loss of balance
__Nervousness
__Cancer
__HIV
__Dizziness
__Depression
__Anxiety
__Shoulder pain
__Neck pain
__Low back pain
__Other
_____
_____
_____

List your hospitalizations, operation, and/or serious illness:

_____
_____

List all the medications you are currently taking:

_____
_____

FINANCIAL POLICY

Sea Girt Spine and Rehabilitation Center
800 Highway 71
Sea Girt, NJ 08750

FINANCIAL POLICY

Thank you for choosing us to provide you with medical care. We are committed to serving you with skill and care. The medical services by our office are services you have elected to receive which may result to a financial responsibility on your part.

CO-PAYS: Co-pays are due at the time of service.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

PROOF OF INSURANCE: We require copies of your driver's license and current insurance card. If a current insurance card is not present, payment in full is required until insurance coverage can be verified.

MEDICARE: We are a participating Medicare provider. Medicare as well your secondary insurance (if any) will be billed for you. You are responsible for co-insurance and/or deductible amounts as stated by Medicare and your secondary insurance company.

PRIMARY INSURANCE: We may or may not be a participating provider for your insurance company. Your primary as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment for deductible amounts as stated by your insurance companies.

NON-COVERED SERVICES: Some services may not be covered or not considered reasonable/necessary by your insurance. Please contact your insurance company with any questions regarding coverage.

PATIENT BILLING: A statement of your financial responsibility (co-insurance, deductible) will be sent to you after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. You will be sent up to two notices. The first statement gives you 21 days to send payment. The second and last notice give you an additional 10 days. Your account may be forwarded to collections, thereafter. Please let the billing office know if you any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Money Order, and Credit Cards.

An additional $35.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, we expect that you would forward it to our office to be applied to your balance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

I have read the above policy regarding my financial responsibility to Sea Girt Spine and Rehabilitation for providing medical services to me or the below named patient. I agree to pay any amount due after payment has been made by my insurance carrier and any contractual adjustments have been credited **OR** the full amount of all bills incurred by me or my dependent if there is no health insurance coverage exists.

PRINT Patient Name: _____ Signature: _____

FINANCIAL RESPONSIBILITY PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient:_____ Date: _____

Informed Consent to Chiropractic Treatment

Coastal Spine and Rehabilitation Center
800 Highway 71
Sea Girt, NJ 08750

The nature of chiropractic treatment: The doctor will use his/her hands on a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter* analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in a conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent.

_____	_____	_____
Printed Name	*Signature*	*Date*

Witness:

_____	_____	_____
Printed Name	*Signature*	*Date*

Coastal Spine and Rehabilitation Center

HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

800 Highway 71
Sea Girt, NJ 08750

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

To use or disclose the following health information.

• All of my health information

• My health information relating to the following treatment or condition:
_____

• My health information covering the period of healthcare from (date) _____ to (date)_____

• Other:_____

The above party may disclose this health information to the following recipient:

Coastal Spine and Rehabilitation Center

Address: 800 Hwy 71 Sea Girt, NJ 08750 Phone: 732.974.7500 Fax: 732.974.1802

Jpetrone@seagirtspine.com

The purpose of this authorization is (check all that apply):

• At my request

• Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

• Patient is a minor: _____ years of age

• Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

• Parent • Legal Guardian • Court Order • Other: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

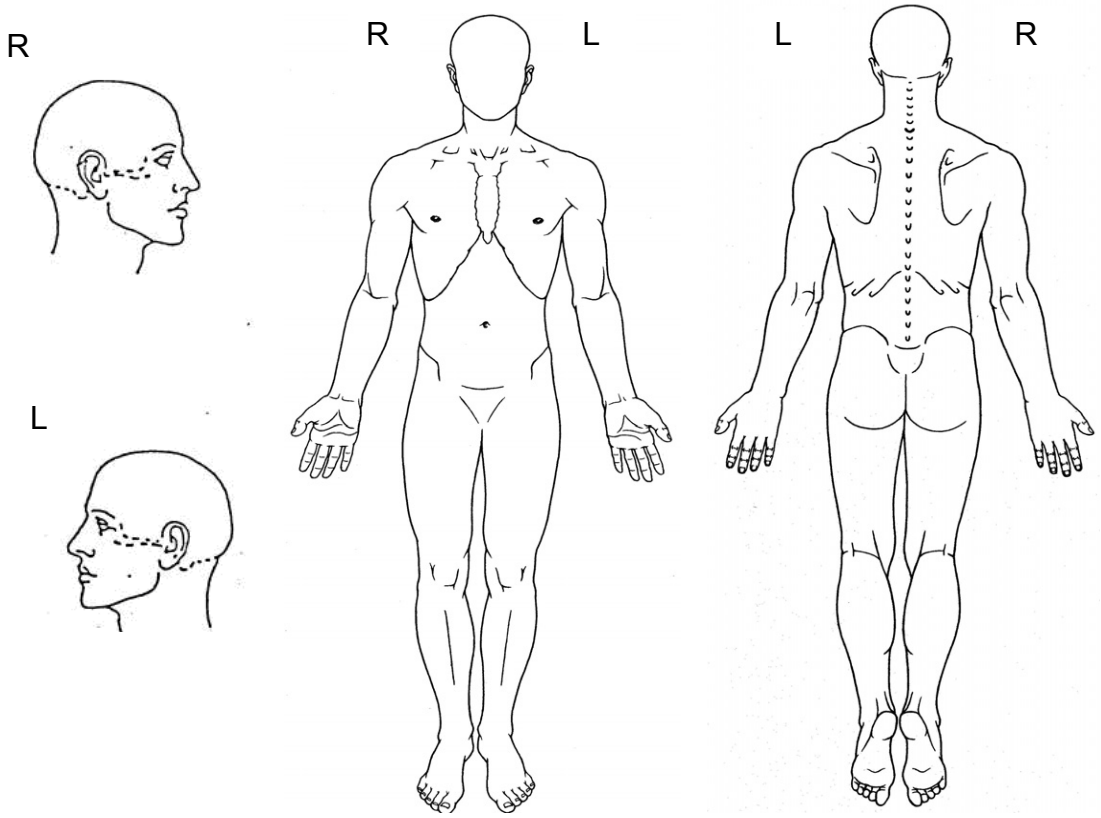
Symptom Diagram

Patient Name: _____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best, represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.

Symbols:

Numbness	≡≡≡≡≡≡≡	Pins and Needles	**ooooo**
Burning	**x x x x x x**	Stabbing & Sharp	~~~~
Dull & Aching	Δ Δ Δ Δ Δ Δ	Stiff & Tight	**2 2 2 2 2**



Front Back