55 US-202, Far Hills, NJ 07931
(908) 956-3984

New Patient Intake Form

Patient Data ________________________________ **Date** ____________

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _______

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

Address Line 1 ____

Address Line 2 ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-__________ **Work Phone (_____)** _________-____________

Cell Phone (_____) ________-____________ **Email** ___________________________________

Date of Birth _____/_____/______ **Sex:** Male Female

Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Primary Care ____

Name ____

Date of Last Visit _________________________ **Date of Last Blood Work** _____________________

Emergency Contact ____

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone (_____)** ________-_______________

How did you hear about our office? ____

Medical Conditions: (Check all that apply to you)

Arthritis Cancer Diabetes Heart Disease
Hypertension Psychiatric Illness Skin Disorder Stroke
Other _______________

Surgeries: (Check all that apply to you)

Appendectomy Cardiovascular procedure Cervical spine Hysterectomy
Joint Replacement Prostate Lumbar spine Gall Bladder
Brain Shoulder Thoracic spine Knee
Carpal Tunnel Gastro-intestinal Uro-genital Hernia
Other _______________

Family History: (Check all that apply)

Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease Parent Sibling
Hypertension Parent Sibling
Stroke Parent Sibling
Thyroid Parent Sibling
Other __________________

Occupational Activities: (Check one that best describes your job description)

Administration Business Owner Clerical/Secretary Computer User
Heavy Equipment operator Daycare/Childcare Construction Health Care
Food Service Industry Medium Manual Labor Manufacturing Home Services
Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
Other _________________

Please list all current medications being taken: Check here if No Medications:______.

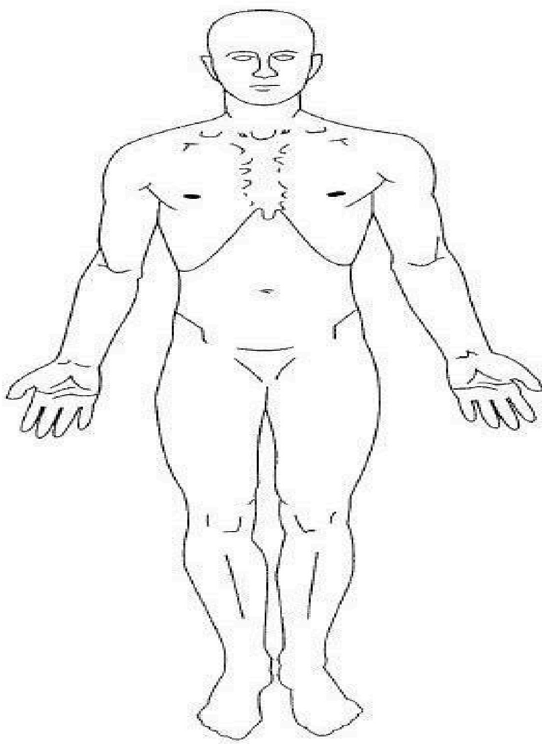
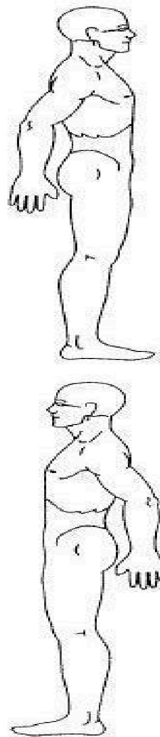
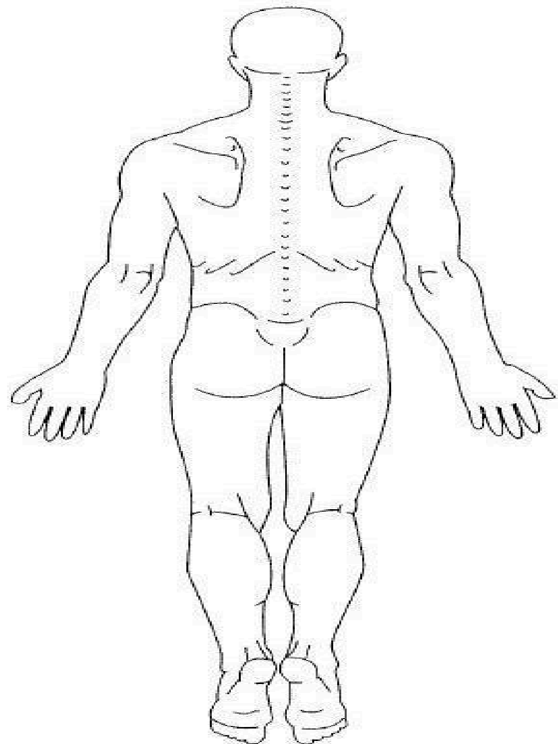
____

____

Are you pregnant? Yes_____ No ______N/A______

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache

Describe your symptoms in order of severity, with worse symptom being #1: ____________________

____

____

____

When did your symptoms begin? Month______________ Day___________Year _______________

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? ____

____

How often do you experience your symptoms?

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

What describes the nature of your symptoms?

Sharp
Dull ache
Numb
Shooting
Burning
Tingling
Stabbing
Other ______

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other ___________________________________

Personal Health Insurance Carrier: _______________________ Insur. Card ID # ___________________

Policy Holder's Name: ________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician _________________

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: ______am / pm

ASSIGNMENT OF BENEFITS

I, [Patient Name], assign to you, my medical provider, all of my rights and benefits under my auto insurance policy and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the Employee Retirement Income Security Act ("ERISA") applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

PATIENT NAME: ____________________ DOB:___________

Patient's Signature: ____

Date: ____/____/_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

a basis for planning my care and treatment a source of information for applying my diagnosis and surgical information to my bill:
a means by which a third-party payer can verify that services billed were actually provided; and
a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for marketing purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:____
____

I authorize medical information to be released to my health insurance carrier including Medicare/CMS for payment of services rendered, to other treating or referring/referral physicians, my attorneys representing any potential claim, and my name, email address and telephone number for marketing purposes.

PATIENT NAME: ____________________ DOB:__________

SIGNATURE: _______________________ DATE: ________

Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, deductibles, co-insurances/co-payments, and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Patient Name: ___________________________________ Date: _____________

Patient Signature: ____________________________________ Date: _____________

Patient Acknowledgement Appointment Cancellation Policy

Dear Patient,

Recharge Chiropractic and Sports Rehab has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need. To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2. A “No-Show”, “No-Call” or missed appointment, without proper 24-hour notification, may be assessed a $30 fee.
3. This fee is not billable to your insurance.
4. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
5. As a courtesy, we make reminder emails and texts, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
6. Repeated missed appointments may result in termination of the physician/patient relationship. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

A copy of this policy will be provided to you. Please sign and date below your acknowledgement. I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name: ________________________________ Date: _____________

Patient Signature: _____________________________ Date: _____________