

Welcome to our office!

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Sex: _____ Marital Status: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone Number: _____ Email: _____

Social Security #: _____ Primary Doctor: _____

Occupation: _____ Company Name: _____

Is this related to: Auto Accident • Yes • No; Work Injury • Yes • No; Slip & Fall Injury • Yes • No

MEDICAL HISTORY:

List any surgical operations and year performed: _____

Do you currently or have you ever suffered from:

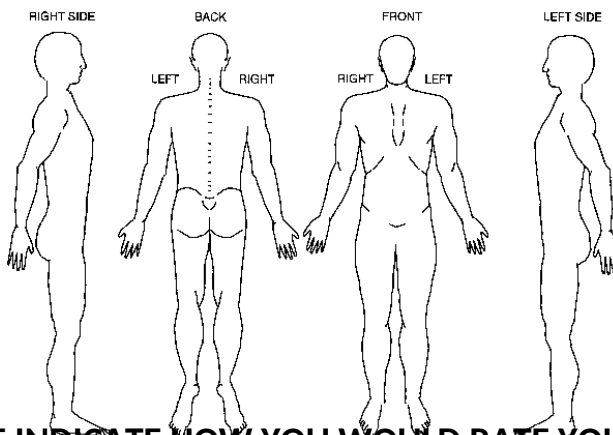
• Pacemaker • Heart trouble • Diabetes • Take blood thinners

Are you currently on prescription medications? • Yes • No If yes, please list: _____

Reason for Visit? _____

PAIN DRAWING: Please mark the figures below with the letters that best describe the sensation or pain you are feeling.

A = Ache	B = Burn	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



PLEASE INDICATE HOW YOU WOULD RATE YOUR PAIN
(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

IN-NETWORK AND OUT-OF-NETWORK INSURANCE NOTICE:

DOCTOR USE ONLY:

- ☐ Neck
- ☐ Shoulder
- ☐ T-Spine
- ☐ Low Back
- ☐ Sciatica
- ☐ Hip
- ☐ Knee
- ☐ Foot
- ☐ Elbow
- ☐ Wrist
- ☐ Headaches

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the insurance providers with which the professional is affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, of the following:

Please be advised that our office accepts most medical insurance providers; however, your financial responsibility can be greatly influenced by whether our office is **in network** or **out of network** with your insurance.

The following is a list of insurance providers that we are **IN-NETWORK** with:

- Horizon (all forms EXCEPT Horizon NJ Health and BCBS Medicare HMO)
- Aetna
- Medicare (including Aetna Medicare and Horizon Medigap)
- Amerihealth
- TriCare (for Physical Therapy patients ONLY: chiropractic DOES NOT accept Tricare)

The following is a list of providers that we are **OUT OF NETWORK** with:

- United Healthcare
- Cigna
- Clover

Please note that we STILL ACCEPT these insurances but that you may have a higher financial responsibility (higher deductibles, coinsurance, et.) due to our being out of network.

The following is a list of insurances we **DO NOT ACCEPT**:

- ANY form of Medicaid (e.g. Horizon NJ Health, United HealthCare Community Plan, any insurance under NJ FamilyCare)

By signing below, you indicate that you have read the above information and undertake chiropractic care and physical therapy on this basis.

Patient's Signature: _____ Date: _____

HEALTH INSURANCE AND FINANCIAL RESPONSIBILITY:

If you have supplied a copy of your card, please write "see card" in the name space. If no insurance, write "none."

MOTOR VEHICLE INSURANCE _____ Phone #: _____

Did you report the accident to your auto insurance? • Yes • No Date of Accident: _____

Claim # _____ Policy # _____

Adjuster Name: _____ Policy Holder: _____ Relationship: _____

IF YOU DO NOT HAVE AUTO INSURANCE, DO YOU LIVE WITH SOMEONE THAT DOES? • Yes • No

Health Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Secondary Health Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? • Yes • No If yes, did you bring it with you today? • Yes • No

All services rendered are charge directly to you, the patient. You then are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment

I understand if I default in paying my portion due, I will be responsible for any and all collection fees, legal cost and attorney fees.

I DO NOT HAVE ANY ADDITIONAL INSURANCE COVERAGE OTHER THAT WHAT I HAVE PROVIDED ABOVE. IT IS MY RESPONSIBILITY TO PROVIDE THIS OFFICE WITH ANY CHANGES OR UPDATES WHEN IT COMES TO MY MEDICAL COVERAGE. IF I DO NOT PROVIDE THE PROPER INFORMATION REGARDING MY COVERAGE, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANYTHING NOT COVERED BY MY INSURANCE COMPANY.

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to pay directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND FULLY ACCEPT ALL OF ITS TERMS.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits - Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Richard Carlson, DC/Rachel Carlson PT, DPT/Optimal Health Chiropractic and Physical Therapy (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient's Signature: _____ Date: _____

OPTIMAL HEALTH CHIROPRACTIC & PHYSICAL THERAPY

Relieving Pain by Restoring Function

We believe a clear definition of our office policy will allow both patient and the doctor to concentrate on the big issues – REGAINING AND MAINTAINING YOUR HEALTH.

TERMS OF ACCEPTANCE

The goal of chiropractic is to relieve pain by restoring function to the human body. Through correcting joint restrictions, muscle imbalances, and faulty movement patterns we are working to help you live a happy and healthier life.

Through the use of joint manipulation, Post Isometric Relaxation, Active Release Technique, Graston, and functional rehabilitation we are working to improve the quality of your joints, muscles, and movements.

Regardless of what disease or condition is called, the chiropractor does not offer to heal or treat it. Nor does the chiropractor offer advice regarding the treatment of disease. The only goal is to allow the body to do its job. The chiropractor promises no cure from and offers no treatment of disease.

I have read the above, understand it fully, and undertake chiropractic care and physical therapy on this basis.

Signature

Date

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Optimal Health Chiropractic and Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Optimal Health Chiropractic and Physical Therapy may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below.

Signature

Dated

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I hereby authorize:

Optimal Health Chiropractic and Physical Therapy/Richard Carlson, LLC
6106 Black Horse Pike, Unit A3
Egg Harbor Township, NJ 08234

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to: Optimal Health Chiropractic & Physical Therapy

Street Address: 6106 Black Horse Pike, Unit A3

City: Egg Harbor Township State: New Jersey Zip Code: 08234

Please indicate the information or types of information to be disclosed, including dates if necessary:

Specify dates (or date ranges) if applicable: _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation should be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information of genetics.

Signature of Patient or Authorized Representative

Date:

HIPAA Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (HCO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use your image and/or name on social media for promotional purposes. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES will be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

Signed

Dated

FOR OFFICE USE ONLY

- Patient Refused to Sign
- Patient Unable to Sign for the following reason _____



I _____, residing at _____

hereby enter into a guarantee of payment with Optimal Health Chiropractic and Physical Therapy/Richard Carlson, LLC, hereafter known as "the provider". I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further services to acknowledge my responsibility to replay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collection effort that is undertaken.

The provider agrees to seek compensation from the appropriate insurance carriers prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, including private health insurance, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claims applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my attorney, _____, to honor the foresaid lien and to withhold such sums from my settlement, judgement, verdict, or any other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me toward any outstanding balances with regard to my accident of _____.

I hereby further instruct that in the event another attorney is substituted in my care that the new attorney honor this lien as inherent to the settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to Optimal Health Chiropractic and Physical Therapy/Richard Carlson, LLC.

Patient's signature

Date



ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my 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.

I authorize you and or your assigned 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 providers 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.

Date

Patient's Signature

Patient's Name



The following is a list of information we will need for your accident case:

- Auto insurance information
- Claim number
- Adjustor name and telephone number
- Attorney information
- Copy of driver's license
- Copy of health insurance card
- Copy of car insurance card
- Declaration page from auto policy
- Police Report

If Physical Therapy patient –

- Script from Primary/Referring Doctor

Please have these documents with you for your first appointment, as we will need them in order to treat you! Thank you in advance!