# Monmouth Spine and Wellness


## 342 RT 9, Suite 1
## Manalapan, NJ 07726
## P : 732 - 252 - 5555 | F : 732-252-5512


Welcome to our office! Whom may we thank for referring you to us? _____

**PERSONAL INFORMATION**

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

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

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____ Social Security #: _____ - _____ - _____

Employer: _____ Occupation/Job Title: _____

Job Address: _____ Work # _____ hours per day

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name: *Last* _____ *First:* _____ # of Children: _____

Insurance Company: _____ ID Number: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: ____/____/____ Relationship: _____

**EMERGENCY CONTACT**

Last Name: _____ First Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Do we have permission to discuss your treatment with your emergency contact? ☐ Yes ☐ No

**HEALTH HISTORY** *FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.*

Primary Care Doctor Name: _____ Date of Last Visit: ____/____/____

Current Medications and Supplements *LIST ANY/ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. PLEASE BE SPECIFIC.* _____

Illnesses *LIST ALL HEALTH CONDITIONS.* _____

_____

Surgeries *LIST ALL SURGICAL PROCEDURES. WRITE THE DATE OF THE PROCEDURE IMMEDIATELY AFTERWARD.* _____

_____

Allergies *LIST ALL KNOWN ALLERGIES.* _____

_____

Family History *LIST ALL KNOWN FAMILY HEALTH CONDITIONS, AS WELL AS THE RELATIVES AFFECTED.* _____

_____

Injuries *LIST ALL INJURIES. WRITE THE DATE OF THE INJURY IMMEDIATELY AFTERWARD.* _____

_____

**SOCIAL HISTORY**

Tobacco ☐ Do not use tobacco ☐ Smoke/Chew (# _____ per Day) ☐ Live with a smoker ☐ Quit smoking

Alcohol ☐ Do not use alcohol ☐ # _____ per Week ☐ # _____ per Month

**REVIEW OF SYSTEMS**

**Nervous System**

| | | | | |
|---|---|---|---|---|
| ☐ Dizziness | ☐ Seizures | ☐ Loss of Memory | ☐ Slurred Speech | ☐ Loss of Consciousness |
| ☐ Strokes | ☐ Tremor | ☐ Limb Weakness | ☐ Fatigue | ☐ Sleep Disturbance |
| ☐ Stress | ☐ Numbness | ☐ Headache | ☐ Loss of Balance | ☐ Tinnitus/Ringing in Ears |

**Respiration**

| | | | | |
|---|---|---|---|---|
| ☐ Nasal Congestion | ☐ Cough | ☐ Wheezing | ☐ Sputum Production | ☐ Shortness of Breath |

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**Cardiovascular**

☐ Palpitations ☐ Varicose Veins ☐ High Blood Pressure ☐ Shortness of Breath ☐ Claudication (Leg Pain/Ache)
☐ Chest Pain ☐ Swelling of Legs ☐ Low Blood Pressure

**Gastrointestinal**

☐ Diarrhea ☐ Indigestion ☐ Abnormal Stool ☐ Vomiting Blood ☐ Difficulty Swallowing
☐ Belching ☐ Vomiting ☐ Abdominal Pain ☐ Constipation ☐ Weight Changes
☐ Nausea ☐ Heartburn ☐ Ulcers

**PRESENT HEALTH CHALLENGE(S)**

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR WELLNESS CARE, CHECK

Explain why you are here today. _____

_____

_____

_____

Has this ever occurred before? Yes No

When do you think this issue started? _____

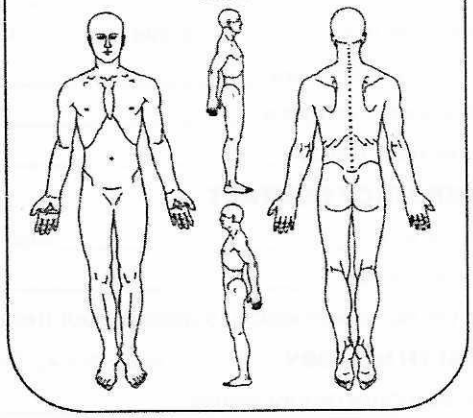
_____

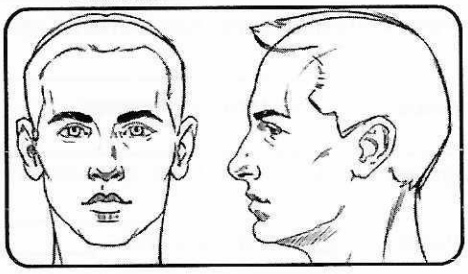
_____

Are your symptoms related to an auto crash or work-related injury?

☐ Yes ☐ No

PLEASE LABEL THE AREA OF DISCOMFORT ON THE BELOW DIAGRAM





**Headaches** ☐ Yes ☐ No *IF YES, PLEASE SELECT QUALITY OF PAIN BELOW AND LABEL AREAS OF DISCOMFORT ON THE DIAGRAM TO THE RIGHT.*

☐ Stabbing ☐ Sharp ☐ Throbbing ☐ Dull

*PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE THE BLANKS WHERE APPLICABLE.*

**Current Symptoms:** ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness ☐ Other _____

**Quality:** ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Tingling
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Other _____

**Timing:** Morning Afternoon Night With Activity Constant Intermittent

**What makes your symptoms worse?** _____

**What makes your symptoms better?** _____

An evaluation will be performed which may include spinal and physical exams, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays). These statements made on this form are accurate to the best of my recollection and I knowingly allow Monmouth Spine and Wellness to examine me for further evaluation/treatment, and understand that I am responsible for all charges incurred.

Signature: _____ Date: _____

**Thank you for allowing us to serve you!**

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## Consent and Acknowledgement of Receipt of Notice of Privacy Practices:

Initials:

_____ **Consent:** I have been informed by my physician of the risks and benefits attendant to the course of treatment and/or therapy (hereinafter "treatment" prescribed by my physician. I understand that it is the opinion of the physician responsible for my care that the benefits of this treatment outweigh the risks of treatment. I fully understand the nature of these risks, including, but not limited to deterioration of my condition, re-injury and/or new injuries. After careful consideration of these risks and benefits, I hereby CONSENT to allow Monmouth Spine and Wellness, and all personnel employed/contracted by Monmouth Spine and Wellness, to perform the treatment and/or therapy specified by my physician, and deemed necessary and/or advisable by Monmouth Spine and Wellness, in accordance with my physician's orders and standards of good clinical practice. I acknowledge that no promises or representations have been made to me regarding the outcome of this treatment.

_____ **Assignment of Benefits:** I hereby authorize any insurer or other entity which may have an obligation to provide benefits for this treatment to directly pay same to Monmouth Spine and Wellness. I also understand that I am primarily financially responsible for all costs of my treatment. Understand that some or all of the costs of my treatment may not be allowable or otherwise covered by Medicare of paid by other insurers. As a courtesy to me, Monmouth Spine and Wellness, may bill my insurer(s) for the cost of my treatment. Monmouth Spine and Wellness, may choose not to accept assignment of benefits; in such cases, I am responsible for paying Monmouth Spine and Wellness, directly for services rendered. In the event that any or all costs of my treatment are denied as non-allowable costs by Medicare, or payment is denied for any reason by any other insurer or agency, I agree to pay the remaining balance of my treatment costs (including any deductibles and/or applicable co-payments to Monmouth Spine and Wellness, within thirty (30) days after I am notified that my insurer has denied any or all benefits of my treatment. Balances unpaid after that time will accrue interest at 1.5% per month or the maximum legal rate. If Monmouth Spine and Wellness, is required to hire an attorney or collection agency or to file a suit to recover any fees owed by me, I agree to pay Monmouth Spine and Wellness, collection agency and attorney fees.

_____ **Authorization for a Designated Representative to Appeal a Determination:** I hereby authorize Monmouth Spine and Wellness, to appeal my plan administrator's determination on my behalf, as my Authorized Representative, and, as a part of the appeal, I hereby authorize my health plan administrator in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain a copy of my Summary Plan Description (SPD) and description of the Plan's Claim Appeal Procedure for the subject period, as well as all medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder, and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of six years unless otherwise limited by the plan or the governing law.

_____ **Patient Request for Records:** From time to time, patients will be sent for advanced medical imaging (MRI, X-Ray, CT Scan, etc.) or our office will have to request records of previous surgeries or procedures from other doctors or hospitals. This section authorizes Monmouth Spine and Wellness to reach out to them on your behalf in order to obtain the necessary records.

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_____ **Agree to Forward Payment:** I am aware that my insurance company may send me payment for services rendered by Monmouth Spine and Wellness, which include chiropractic, physical therapy, and acupuncture. I agree that any when I receive payments for those services, I will: 1. Sign the check and I WILL NOT DEPOSIT OR CASH IT. (Personal checks will only be accepted on multiple payer insurance checks). 2. Under my signature, I will print the following: "Make Payable Only to Monmouth Spine and Wellness". 3. I will enclose the check with ALL OTHER PAGES ACCOMPANYING THE Check, such as Explanation of Benefits, etc. 4. Place all of the above in an envelope and mail immediately to:

Monmouth Spine and Wellness
342 RT 9 , Suite 1
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I also understand that in the event the check is not immediately sent to the adress above , I will be responsible to pay the full and entire fee for all services rendered, plus 12% interest and any additional collection fees and legal costs in connection with collecting this debt. I agree that Monmouth Spine and Wellness, is hereby given the right to endorse/sign my name on any and all checks for payment of my bills, in connection with services provided by Monmouth Spine and Wellness.

_____ **Acknowledgement of Receipt of Notice of Privacy Practices:** I have been given a copy of Monmouth Spine and Wellness Notice of Privacy Practices ("NPP"). I have had the opportunity to review the NPP and to ask questions regarding the contents of the NPP. My questions about the NPP were answered to my satisfaction.

_____ **Cancellation Policy:** If I fail to call and cancel my appointment 24 hours prior, Monmouth Spine and Wellness reserves the right to bill me a cancellation fee of $25.00.

I have read this form; all of my questions about the contents of this form have been answered to my satisfaction, and I fully understand the contents of this form.

Patient Signature: _____ Date: _____

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## Billing and Office Policies

INSURANCE: Monmouth Spine and Wellness will gladly submit your claims to insurance carriers. In order to do so, we need your cooperation. Complete and current insurance information is required in order for our office to submit a claim to your primary insurance plan. This information needs to be provided at EACH visit or you may be required to reschedule or make payment at the time of service. It is the patient's responsibility to notify Monmouth Spine and Wellness of any changes in or termination of their insurance. If using a parent's insurance, the patient must sign accepting financial responsibility if not covered with the EXCEPTION of minors. **Monmouth Spine and Wellness is an out of network practice and will bill as such.** HRA plan payments are subject to the insurance carrier's discretion, rates will be paid at a UCR out of network rate.

REFERRALS: It is the patient's responsibility to make sure that the referral has been obtained from their Primary Care Physician and to bring a copy of that referral to our office. If you do not have a referral you may be asked to reschedule your appointment or you may choose to pay in full for services that day.

CO-PAYS, COINSURANCE, AND DEDUCTIBLES: Co-pays are fixed amounts that your insurance plan has designated as your responsibility for each office visit. This amount may be collected prior to your office visit, unless there are prior arrangements made waiving the co-pay for that day. If coinsurance or deductible is applied to your responsibility instead, you may be billed for the additional amount once your insurance processes the claims or if prior arrangements have been made.

MEDICARE: Our providers are participating with Medicare Part B and will bill for services provided. You will be responsible for any deductible or co-insurance. We will submit to a secondary insurance as a courtesy. If payment is not received within 60 days, you will be billed for the amount owed as per Medicare. If you would like to submit your secondary insurance, we will gladly issue you a receipt for services rendered.

WORKER'S COMP & MOTOR VEHICLE ACCIDENTS: We will bill the insurance carrier directly. You are responsible for providing the complete claim information, claim address, and adjuster's contact information. If your worker's comp or PIP insurance denies your claim, we will bill your medical insurance if the appropriate information or referrals needed were provided in a timely manner. We will await result of any litigation to receive payment. We do accept "Letters of Protection". You will not be billed for any patient co-insurance, deductibles, or if claims are denied during treatment provided this agreement is signed.

SELF PAY: If you do not have medical insurance coverage, payment as per the Monmouth Spine and Wellness fee schedule is required at time of service.

AUTHORIZATIONS: Prior authorizations are required by some insurances for certain services whether provided in our office, hospital, or at a radiology facility. Patients should know their insurance plan and should advise front desk personnel that authorization is required prior to your visit. We will gladly submit the authorization for you. If

authorization is not given prior to date of service you may have to reschedule and/or pay in full for services that day.

RETURNED CHECKS: If a check you issued as payment is returned by your bank (for any reason) you will be charged a fee of $20.00. Any future payments to our office may be required to pay cash or credit/debit card ONLY.

INSURANCE PARTICIPATION STATUS: The laws of the State of New Jersey and New Jersey Department of Health requires that a healthcare professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that the health plans Monmouth Spine and Wellness participates with are listed below. If the patient's health plan is not listed below, the physician and/or facilities providing services do not participate with the patient's health plan.

Novitas Solutions Medicare
MedRisk EPO

I have read and understand the above policy regarding my financial responsibility to Monmouth Spine and Wellness, and my failure to fulfill my financial obligation may cause interruption or delays in my care. I agree to the below:

- We will bill your insurance company on a 30-day cycle as long as you are receiving chiropractic, physical therapy or acupuncture in this office.
- Our office does NOT guarantee that your insurance company will pay. We will make every attempt at the beginning of your healthcare to receive verification of your policy and what it covers. However, if for some reason your insurance claims are denied, you are responsible for the full amount of the bill.
- Should your insurance company request written reports regarding your condition, progress, or other similar information, there may be an additional fee.
- Monmouth Spine and Wellness reserves the right the pursue any delinquent claims in any mannerism deemed necessary.
- Accuracy of documentation is of the highest importance; therefore, office notes will be available for request 30 days after visit due to internal auditing.

| Print Patient Name | Patient Signature | Date |
|---|---|---|