

PARAMUS

MEDICAL & SPORTS REHABILITATION CENTER

205 Robin Road, Suite 118 - Paramus, NJ 07652

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

SS# _____ DOB _____ M _____ F _____

Employer _____ Business Phone _____

Spouse _____ DOB _____

Emergency Contact _____ Phone _____

Referred to us by _____ Phone _____

Is this a motor vehicle accident _____ work injury _____ other _____

Date of accident _____ Attorney _____ Phone _____

Insurance _____ ID/Claim # _____

Address _____

Adjuster _____ Phone _____

Purpose of appointment _____

Other treating Doctor _____ Phone _____

Doctor _____ Phone _____

Medication _____ Dose _____ Mg _____

Medication _____ Dose _____ Mg _____

Medication _____ Dose _____ Mg _____

205 Robin Road • Suite 118 • Paramus, NJ 07652

Phone: 201.225.1511 • Fax: 201.225.9731 • Toll-free: 888-Low.Back • visit us online: ParamusMedicalandSports.com

Allergies _____

Past Surgeries _____

Past Hospitalizations

Diagnostic Tests:

X-Rays _____ MRI _____ CT Scan _____ EMG _____

- | | | | |
|--|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigars | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Confusion | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Light-Headed | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Speech | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other |

Family History _____



OFFICE POLICY/FINANCIAL POLICY

Patients are required to complete all necessary paperwork.

Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will ensure that you get the treatment results you deserve.

Patients without insurance coverage are expected to pay in form of cash, check, or credit card the same day services are rendered.

For our patients with assignable insurance coverage we have made an effort to remove the financial burden of your health care bills. We are one of the few healthcare providers that will accept assignment of benefits. Our center will render treatment and wait to be reimbursed by your insurance company.

We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.

HMO/PPOs: Please be secure that we are participating in your plan and any precertification and/or referrals are the patient's responsibility.

This office is unique in its ability to offer Chiropractic, Acupuncture, Physical Therapy and Massage Therapy. Please understand that any treatment prescribed is done on the basis of medical necessity in order to resolve your condition and prevent recurrence.

Please feel free to ask any questions that remain unanswered, we wish to be of assistance in any way we can.

THANK YOU FOR CHOOSING PARAMUS MEDICAL & SPORTS REHABILITATION CENTER FOR ALL OF YOUR HEALTH CARE NEEDS!!!

Patient's Name

Date

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PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry to the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. Understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or maybe liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

HMO DISCLAIMER: I certify that I am not enrolled in any Health Maintenance Organization (HMO) Subsequent rejection of a claim as a result of this admission, due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFROMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII and/or Title XI of Social Security Act is correct. I authorize any holder of medical or other information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

PREGNANCY: By my signature on this form I do hereby state that to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient's Name

Date

**Legal Assignment of Benefits and Release of
Medical and Plan Documents**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee benefits coverage with _____ and hereby assign and convey directly to Paramus Medical and Sports Rehabilitation Center LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and of outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage any any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

DATE

Relationship to Guardian to Minor Child _____



PRIVACY PRACTICES ACKNOWLEDEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate _____

Signature _____

Date _____