Bergen County Rehab OWCP New Patient History

Date:_____

Job / Injury Details:

1. What is your Name?
2. What is the reason for your visit?
3. What part of the body was injured?
4. Date of Injury?
5. Do you have a Case number for this injury? If so, what is the current status of the case?
6. If the case was denied, what was the reason?
7. If the case was accepted, were all the diagnosis that the doctor requested accepted?
8. What were you doing that you injured this body part?
9. If this is an occupational disease please describe your job responsibilities?
10. Do you have any hobbies? If so what kind?
11. Have you seen a doctor for this injury? If so, who, what type of doctor, and when?
12. Do you have any XRAYs? MRIs? EMGs?
13. Do you have a copy of CA1/ CA2 or CA16?
14. Have you been referred for any treatments? (i.e. Physical Therapy, Meds, surgery)
15. Is the treatment helping the condition or is it not getting any better? or possibly worse?
16. What is your job title and How many years have you been working?
17. Have you ever had this type of injury/condition before? If so, when?
18. Do you have documentation for those injuries?
19. Do you have any other Claim numbers or previously reported injuries?

20. Have you returned to work?

21. At what capacity have you returned to work? Limited…?

22. What are you looking to have me do?

Bergen Rehab

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: Today's Date:__

Address:_____

City/State/Zip:_____E-Mail:_____

Phone: Home_____Work:_____Fax:_____

Cell #:_____Pager:_____Marital status: M/W/D/S

Birthdate:_____/____/_____Age:_____Social Security #:_____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic and address:_____

Chiropractic techniques you've had success with:__

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner name:_____Phone: _____

Other Specialists you are currently under care with:

Name:_____Phone: _____

Name:_____Phone: _____

Name:_____Phone: _____

Employer name:_____Phone: _____

Employer's address:_____

Occupation:_____

Spouse's name:__

Spouse's employer:__

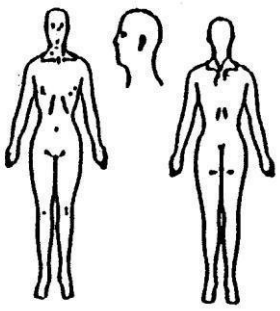
Children's names & ages:_____

Favorite hobbies or interests:_____

_____

Method of payment for first visit:
_____Cash_____Check_____MAC_____Credit Card

Mark area(s) of Health Concerns



Bergen County Rehab
299 Market Street, Suite 140 Saddle Brook, NJ 07663

Health reasons for consulting our office:
1._____ 2._____

3._____ 4._____

Have you had same or similar problem(s) before?___Yes____No
How long?:_____ Please explain:

_____

_____

Father/Mother/Brother/Sister/Children, with similar problems?

_____

Is this the result of an auto or work injury?_____If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

_____

Other doctors who have treated this problem:_____

_____

Surgery you have had:_____

Medication(s) you currently take:_____

Is there any chance you are pregnant? Yes_____No_____

What have you heard about chiropractic care?

_____

Do you know what a subluxation is? If yes, please describe

_____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer?____If so, what type?

_____

Do you have health insurance?_____Name of company:_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____Date: / /____

Bergen County Rehab
299 market street, Suite 140 Saddle Brook, NJ 07663

NOTICE OF PRIVACY PRACTICES
And Informed Consent

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 privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule (HIPAA) governing protected health information. This notice tells you about how it may be used, and about certain right that you have**.**

Bergen county rehab and wellnesses is in charge of privacy matters in the office.
You can contact us at 201-885-3200 if you wish to make an appointment with us regarding question or concerns.

Use and Disclosure of Protected Information

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law requires that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law requires that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, our accountants may see your name, dates of treatment and procedure codes during any audit(s) of our books.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for health purposes;
3. Required by law to report child abuse;
4. Required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Misconduct;
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposes by law enforcement official;
7. Required by a coroner or medical examiner:
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you a re a member of the armed forces of the United States.

New York State Law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State Law with respect to such information.

We may contact you by mail or telephone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may lease a message for you on any answering device or with any person who answers the telephone at your residence.

You may make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization,. You have the right to revoke any written authorization that you give.

Rights That You Have

You have the right to request restriction on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged for the secretary's time plus copying charge).

You have the right to request amendments t your medical information. Such requests must be made in writing, and must state the reason for the requested amendment. We will notify you as to whether or not we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information except for: disclosures we make to you or to carry out treatment, payment or health care operation; or as requested by your written authorization; or as permitted or required under 45 CFR 164.502; or for emergency or notification purposes; or for national security or intelligence purposes as permitted by la; or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being identified or limited t remove personally identifiable information); or disclosures made before April 14, 2003.

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Obligation That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of your legal duties and privacy practices.
We are required to abide by the terms of notice as long it is currently in effect.
We reserve the right to revise this notice and to make a new notice effective for all protected health information we maintain. Any revised notice will be posited in our office and copies will be available there.
If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us.

Complaints should be directed to: Bergen County Rehab
2 99 market street, Suite 140 Saddle Brook, NJ 07663

I have read and understand my legal rights.

_____ _____/_____/_____

Patient Signature

ASSIGNMENT, LIEN, AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Bergen County Rehab 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. 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 health care benefits coverage under any applicable insurance policies and or employee health care 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 or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

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

Patient:_____ Date: _____

Witness:_____ Date: _____