CHIRO REHAB CENTER

220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Patient Information

Name: _____

Address: _____

City: _____ **State:** ___ **Zip:** _____

Date of Birth: ___/___/___

Social Security Number: _____

Contact Information

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Cell phone carrier (for appointment reminders only)**:**

◯ Verizon ◯ AT&T ◯ Sprint ◯ T-Mobile

◯ Other: _____

Race: ◯ White ◯ Asian ◯ African American ◯ Hispanic ◯ American Indian ◯ Prefer not to answer ◯ Other: _____

Sex: ◯ Male ◯ Female ◯ Other ◯ Prefer not to answer

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Other

Name of Spouse: _____

Employer: _____

Insurance Information

Are you covered by any health insurance?

Insurance Company: _____

ID Number: _____

Group Number: _____

Name of Insured: _____

Relationship to you: _____

Reason for Visit _____

_____

_____

Are any other Doctor(s) treating you for this problem? ◯ Yes ◯ No

Name: _____

Phone Number: _____

Were you in an accident? ◯ YES ◯ NO

☐ Motor Vehicle Accident ☐ Fall

☐ Worker's Compensation ☐ Lifting

☐ Other: _____

If motor vehicle accident, please provide details in the dedicated section on the following page.

Have you had any serious illness' in the past?

◯ **No** ◯ **Yes:** _____

Is there any chance you are pregnant? ◯ Yes ◯ No

I understand that AKM Chiro-Rehab Center, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the AKM Chiro-Rehab Center, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurane information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize AKM CHiro-Rehab Center, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission ro leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

PATIENT SIGNATURE: _____ **DATE:** _____
(Guardian's signature if patient is a minor)

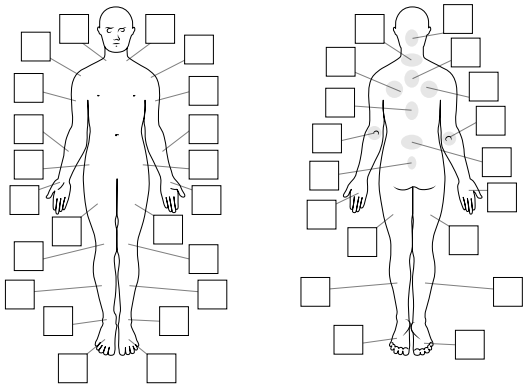
Translated by: _____

PATIENT NAME: _____ **DATE:** _____

Rate the level of pain you are experiencing on a scale of 1-10 (1 minimum - 10 maximum)

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Where are you having your pain?
Please indicate a P for pain, N for numbness and T for tingling.



How did your pain begin? ○Suddenly ○Gradually

Is your pain constant? ○Yes ○No

Do you have any existing pain/symptoms from a previous incident? ○Yes ○No

Have you ever had similar symptoms? ○Yes ○No

When? _____

Treatment received: _____

_____

Are you currently working? ○Yes ○No

What activities can you no longer do as a result of this injury? _____

_____

Are you disabled as a result of this injury? ○Yes ○No

Medical History

Check any and all medical conditions that apply to you.

- ☐ High Blood Pressure
- ☐ Asthma/Lung Disease
- ☐ Heart Disease/Arrhythmia
- ☐ Arthritis
- ☐ HIV or Exposure
- ☐ Congestive Heart Failure
- ☐ Kidney or Liver Disease
- ☐ Pacemaker
- ☐ Head Injury
- ☐ Spinal Injury
- ☐ Spinal Surgery
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Gastritis or Ulcers
- ☐ Cancer
- ☐ Stroke/Seizure
- ☐ High Cholesterol
- ☐ Other

Past Surgical History

Please list any surgeries you've had and approximate dates.

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

Please fill out this shaded section ONLY if you were involved in an automobile accident.

Date of accident: ___/___/___

Time: _____ ○AM ○PM

Location: _____

Did you have a seat belt on? ○Yes ○No

Were you the: ○Driver ○Front Seat Passenger ○Rear Passenger: Left ○Pedestrian ○Rear Passenger: Middle ○Bicyclist ○Rear Passenger: Right ○Motor Cyclist

Type of impact: ○Head On ○Rear End ○Left Side ○Right Side

Auto Insurance Company: _____

Claim Number: _____

Policy Number: _____

Did any part of your body impact anything inside the car? ○Yes ○No

If yes, describe: _____

Did you lose consciousness? ○Yes ○No

Did you go to the hospital? ○Yes ○No

How did you get to the hospital?

_____

What was done at the hospital?

_____

Do you have an attorney? ○Yes ○No

Attorney Name: _____

Attorney Phone Number: _____

Family History Place an “x” in appropriate boxes to identify all illnesses/conditions in your blood relatives.

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon or Rectal Cancer								
Other Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Liver Disease								
High Cholesterol								
Alcohol/Drug Abuse								
Depression/Psychiatric Illness								
Genetic (inherited) Disorder								
Stroke								
Other								

Medications

Prescription Medications	Dosage Strength	How Often Taken

Non-Prescription (List over the counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Non-Prescription Medications	Dosage Strength	How Often Taken

PATIENT NAME: _____ **DATE:** _____

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Pain Evaluation Form

Name: _____ Date: _____

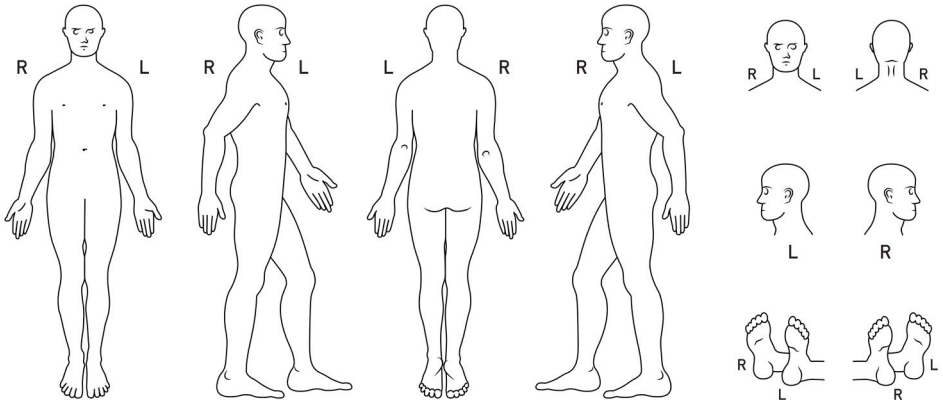
Circle where it hurts on the chart & use the lines below to best describe the type of pain you feel.

_____

_____

_____

sharp, aching, tingling, throbbing, numbness, shooting, deep, dull, hot, cold, burning, cramping, itchy, swelling, spasm, sensitive, etc.



1. Do you take any medication for your pain? (*Over-the-Counter or Prescription*) ◯Yes ◯No

If yes, what: _____

Frequency? _____

2. Does the pain radiate? ◯Yes ◯No ◯Sometimes

3. Is the pain constant? ◯Yes ◯No ◯Sometimes

4. Does anything cause, increase, or aggravate the pain you're experiencing? ◯Yes ◯No

If yes, what: _____

5. Does anything decrease or alleviate the level of pain you're experiencing? ◯Yes ◯No

If yes, what: _____

6. Over the past month, what percentage has your pain interfered with your daily activites?

(i.e.: housework, washing, dressing, walking, eating, sleeping, going to the bathroom, climbing stairs, getting in or out of beds and chairs, etc.)

7. Has the area where you experience pain increased or decreased in size since you began treatment with us?

◯Increased ◯Decreased ◯No change

8. Has your overall level of pain increased or decreased since beginning treatment?

◯Increased ◯Decreased ◯No change

9. Are you performing your exercises as instructed?

10. Evaluate your pain over the past week. On the pain scale below, please place a "**C**" at your current pain level, followed by a "**W**" for the worst level of pain you experienced, and an "**L**" for the least level of pain over the course of the past week. *(1 Minimum - 10 Maximum)*

1 2 3 4 5 6 7 8 9 10

The following section is to be completed by your Doctor

	Flex.	Ext.	R. Rot.	L. Rot.	R. Lat.	L. Lat.
Cervical						
Lumbar						

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Consent to Treat

I, hereby authorize Dr. Karen Mennella DC, Dr. Anna Kazmierczak DPT and whomever they may designate as their assistants to administer chiropractic and physical therapy services as they deem necessary.

Patient Name: _____

Signed before us on this _____ Day of _____ 20___

_____
(Patient/Parent/Guardian Signature)

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Authorization of Disclosure of Protected Health Information by another Covered Entity for Use by AKM Chiro-Rehab Center, LLC

Information to Be Used or Disclosed
Information to be obtained under this authorization includes: Medical records

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
• Third party billing and/or collection services
• Transcription services
• Interpreters for translation

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Legal representatives of AKM Chiro-Rehab Center, LLC

Persons to Whom Information may be Disclosed
Information described above may be disclosed to:
Legal representatives of AKM Chio-Rehab Center, LLC and their associates

Expiration Date of Authorization
This authorization unless revoked or terminated by the patient or the patients' personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to AKM Chiro-Rehab Centerm LLC. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual
• You may inspect or request a copy of information that is used or disclosed under this authorization.
• You may refuse to sign this authorization.

_____ _____
Name of Patient (Print) (Date)

_____
(Patient/Parent/Guardian Signature)

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Payment Acknowledgment

I, _____, have been informed
(print name)
AKM Chiro-Rehab Center, LLC, is not participating with my health insurance carrier.

I understand that since AKM Chiro-Rehab Center, LLC is a non-participating provider that all treatment rendered will apply to my out of network benefits and that I may have additional out of pocket costs such as non-covered services, deductible and/or co-insurance responsibility.

I also understand that any payments from my insurance made out in my or my subscriber's name and/or sent to my address shall be promptly given to AKM Chiro-Rehab Center, LLC with the appropriate endorsements and a copy of the explanation of benefits (EOB).

I furthermore understand that any payments from the insurance company deposited by me into my personal bank account with no corresponding prompt payment made by me to AKM Chiro-Rehab Center, LLC can be considered theft of services, which could result in my account being referred to collections and possibly being held personally liable in a competent New Jersey court of law.

Lastly, I shall provide AKM Chiro-Rehab Center, LLC with any secondary insurance coverage to cover some if not all of the balance due. If no secondary insurance is provided I understand that I will be 100% liable for outstanding balances and agree to pay and/or negotiate the balance due.

_____ _____
(Patient/Parent/Guardian Signature) (Date)

_____
(Witness)

Translated by: _____
(Employee Name)

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Medical Record Request

To: _____

Address: _____

City, State & Zip: _____

I, hereby authorize the release of my Medical records or copies of such and request that they be sent to the provider mentioned below:

AKM Chiro-Rehab Center, LLC

_____ _____
(Name of Patient) (Witness)

_____ _____
(Patient/Parent/Guardian Signature) (Dates of Service)

Patient's Date of Birth: _____

Patients SSN: _____

Thank you in advance for your cooperation in providing us with the requested information.

Should you have any questions, pleae feel free to contact us at the number up top.

Translated by: _____
(Employee Name)