THE SPINE & HEALTH CENTER OF MONTVALE

2 South Kinderkamack, Suite #208 Montvale, NJ 07645
T: 201.746.6577 info@thespineandhealthcenter.com
F: 201.746.6576 www.TheSpineandHealthCenter.com

NEW PATIENT INFORMATION

Please complete **all of the following information as accurately as possible.**

How did you hear about our office? ☐ *Internet/Web* ☐ *Sign* ☐ *Friend* ☐ *Patient* ☐ *Promotion* ☐ *Other:*

If referred by a patient, please advise by whom : _____

PATIENT INFORMATION

Full Name:		**Date:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Email:		**Marital Status:**	
Address:	**City:**	**State:**	**Zip:**
Employer:		**Occupation:**	
Employer Address:	**City:**	**State:**	**Zip:**

SSN:	**Date of Birth:**	**Age:**	**DL #:**	**State:**

PRIMARY INSURANCE

Company Name:	**ID #:**	**Group #:**
Insured's Name:		**Telephone #:**
Insured's DOB:	**Insured's SSN:**	
Relationship to Patient:	**Insured's Employer:**	

SECONDARY INSURANCE - (IF APPLICABLE)

Company Name:		
Company Address:	**City:**	**State:**
Telephone #:	**Insured's SSN:**	

EMERGENCY CONTACT

Name:	**Relationship:**	**Telephone #:**

PRIMARY CARE PHYSICIAN - (MEDICAL DOCTOR)

Full Name:			
Address:	**City:**	**State:**	**Zip:**

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you ever been to a chiropractor before?	☐ **NO**	☐ **YES**	**If "YES", when?**
2. Were you ever injured in an automobile accident either as a passenger or driver?	☐ **NO**	☐ **YES**	**If "YES", when?**
3. Were you ever injured at work as a result of employment?	☐ **NO**	☐ **YES**	**If "YES", when?**

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CHIEF COMPLAINT(S)

What primary symptom prompted today's visit?

What other symptoms are you experiencing, if any?

Have you seen anyone else for this condition? ☐ NO ☐ YES

If "YES", who else have you seen? (Include Hospital/E.R. visits and names of physicians. Please note details, if known.

If you need additonal space, use back of this page. If any of these practitioners referred you here, please indicate that as well.)

When did you first experience the problem that prompted your visit?

Onset Characteristics: ☐ Occurred Suddenly ☐ Occurred Gradually ☐ Progressivley worsend over time

Do you have a personal or Family history of cancer/malignancy?

If "Family", please indicate family relation: ☐ NO ☐ YES, Personal ☐ YES, Family

Do you have any personal or Family history of Diabetes?

If "Family", please indicate family relation: ☐ NO ☐ YES, Personal ☐ YES, Family

Do you have any other pertinent personal of family history? ☐ NO ☐ YES, Personal ☐ YES, Family

If "YES", pleast list:

CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS

- ☐ Allergies
- ☐ Anemia
- ☐ Arm/Shoulder Pain
- ☐ Arthritis
- ☐ Asthma/Difficulty Breathing
- ☐ Bladder Infection
- ☐ Buzzing/Ringing Ears
- ☐ Cancer
- ☐ Chest Pain/Heart Trouble
- ☐ Cold, Tingling Extremeties
- ☐ Concentration Loss
- ☐ Constipation/Diarrhea/Colon
- ☐ Convulsions/Epilepsy
- ☐ Cold Sweats
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Gallbladder Symptoms
- ☐ Head seems too Heavy
- ☐ Headaches/Migraines
- ☐ Hepatitis/Liver Symptoms
- ☐ Hip Pain
- ☐ Indigestion/Stomach
- ☐ Insomnia/Sleeping Problems
- ☐ Joint Pain
- ☐ Kidney Problems
- ☐ Light Bothers Eyes
- ☐ Loss of Energy
- ☐ Loss of Memory
- ☐ Loss of Smell/Taste
- ☐ Low Back Pain
- ☐ Menstrual Pain/PMS
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness
- ☐ Pain Down Legs
- ☐ Pinched Nerves
- ☐ Poor Circulation
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Sinus
- ☐ Stress/Tension
- ☐ Tight Muscles
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Vision Blurred
- ☐ Weight Loss
- ☐ Other

If "Other", please list here:

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UNDERSTANDING YOUR CONDITIONS AND SYMPTOMS

****Directions:** Please place an (X) in the appropriate complaint areas.

SPINE

- ☐ Low Back
- ☐ Mid Back
- ☐ Neck
- ☐ Pelvis

UPPER EXTREMITY

- ☐ Shoulder R/L
- ☐ Arm R/L
- ☐ Elbow R/L
- ☐ Wrist R/L
- ☐ Forearm R/L
- ☐ Hand R/L

LOWER EXTREMITY

- ☐ Hip R/L
- ☐ Thigh R/L
- ☐ Knee R/L
- ☐ Leg R/L
- ☐ Ankle R/L
- ☐ Foot R/L

OTHER - (PLEASE DESCRIBE)

SUBJECTIVE PAIN LEVEL

ON A SCALE OF [1] - [10], PLEASE MARK AN (X) FOR YOUR CURRENT PAIN LEVEL.

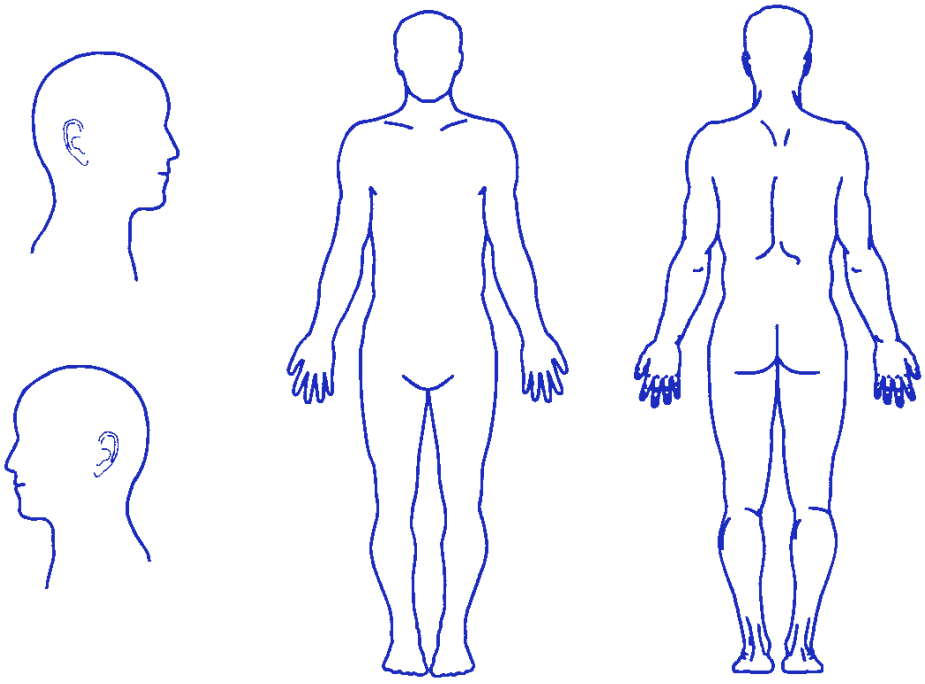
NORMAL:	☐ 0		
LOW PAIN:	☐ 1	☐ 2	☐ 3
MODERATE PAIN:	☐ 4	☐ 5	☐ 6
INTENSE PAIN:	☐ 7	☐ 8	☐ 9
EMERGENCY:	☐ 10		

DIRECTIONS:

Using our Discomfort Symbols below, please mark your areas of discomfort as it pertains to your current condition and area of the body.

DISCOMFORT SYMBOLS

- **A** = Aching
- **B** = Burning
- **C** = Cold
- **H** = Hypersensitivity
- **N** = Numbness
- **R** = Throbbing
- **S** = Stabbing
- **T** = Tingling



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PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ☐ I have missed work because of my symptoms.
- ☐ The quality of my work/productivity at work has been affected.
- ☐ I am unable to perform routine household chores.
- ☐ My social life has suffered because of my symptoms.
- ☐ My symptoms have interfered with my ability to spend time with family and friends.
- ☐ I am unable to participate in recreational activities because of my symptoms.

CURRENT MEDICATIONS - (AND DOSAGES, IF KNOWN)

☐ None ☐ Yes If "Yes", please list below:

PREVIOUS SURGERIES

☐ None ☐ Yes If "Yes", please list below:

PREVIOUS HOSPITALIZATIONS

☐ None ☐ Yes If "Yes", please list below:

PREVIOUS SIGNIFICANT ILLNESSES

☐ None ☐ Yes If "Yes", please list below:

PREVIOUS INJURIES AND TRAUMAS

☐ None ☐ Yes If "Yes", please list below:

PREVIOUS HISTORY OF SIMILIAR CONDITION(S)

☐ None ☐ Yes If "Yes", please list below:

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ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE

I hereby give my authorization to treat me or my minor child as named herein on this form. Our office policy requires **payment in full** for all services and goods rendered at the time of your visit to the office, unless other arrangements have been made with the Office Manager.

I clearly understand and agree that all services and goods rendered to me are charged directly to me, and I am ultimately personally responsible for payment.

I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable at the regular rates, irrespective of any concessions made, discounts applied and/or other such arrangements.

I hereby authorize payment of any and all benefits, medical or otherwise, directly to the physician for benefits due me for the services and/or goods rendered.

I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. We do not offer to treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of an examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information.

Date : _____
(MM/DD/YYYY)

Patient Name or Parent/Guardian if patient is a minor: _____
(Please Print First Name & Last Name)

Patient Signature or Parent/Guardian if patient is a minor: _____

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ASSIGNMENT OF BENEFITS

Patient Full Name :		**Employer:**
Claim Group:	**SS# / ID#:**	**Date:**

I hereby instruct and direct _____ **Insurance Company to pay by check made out to:**
(Print Name of Insurance Company)

THE SPINE AND HEALTH CENTER OF MONTVALE
2 South Kinderkamack Road
Montvale, NJ 07645
Tel: 201.746.657 Fax: 201.746.6567

OR

If my current policy prohibits direct to doctor, I hereby also instruct and direct you to make out the check to me and mail it to this office for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, incurrent manner, any balance of said professional services charged over and above this insurance payment.

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

I also authorize the doctor initiate a complaint to the Insurance commissioner for any reason on my behalf.

Patient Signature:	**Date:**
Signature of Witness:	**Date:**
Signature of Claimant, if other than policyholder:	**Date:**

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PAYMENT & APPOINTMENT CANCELLATION POLICIES

We are committed to providing you with the best possible care. Please read carefully and sign at the bottom of the page indicating your acceptance of our policies and procedures.

1. **PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.**

   - Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
   - Not all services are covered by all insurance policies. Some companies select certain services that they will not cover
   - The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
   - If your account becomes past due and goes to our collections agency, you are responsible for all fees incurred.

2. **OUR OFFICE PRIDES ITSELF ON OUR ABILITY TO SEE PATIENTS IN A TIMELY MANNER. WE THEREFORE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATIONS. REPEATED SAME DAY CANCELLATIONS OR NO-SHOWS WILL REQUIRE US TO TAKE A $49 HOLD FEE VIA CREDIT CARD WHICH WILL BE CHARGED AT THE TIME THE APPOINTMENT IS MADE IN ORDER TO BOOK ANY FUTURE APPOINTMENTS. THIS $49 WILL BE CREDITED TO YOUR ACCOUNT (CO-PAY, DEDUCTIBLE, NON-COVERED SERVICE) AFTER YOU COME IN FOR THE APPOINTMENT.**
   1ST CANCELLATION: ADVISED OF CANCELLATION POLICY
   2ND CANCELLATION: ADVISED OF POLICY REGARDING HOLD FEE
   3RD + CANCELLATION: $49 HOLD FEE TO BOOK FUTURE APPOINTMENTS (CREDITED TO PATIENT ACCOUNT AFTER VISIT)

3. **I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO THE SPINE & HEALTH CENTER OF MONTVALE.**

   - This is a direct assignment of my rights and benefits under my health insurance policy. I agree to pay any balance of professional services charged over and above this insurance payment.
   - If my current policy prohibits payments directly to the doctor, I agree to mail the check (original or personal) as payment for services rendered.

4. **I HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.**

Patient/Policy Holder Name *(Please Print)*

Patient/Policy Holder Signature | **Date**

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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 Spine and Health Center of Montvale is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment

We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

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DISCLOSURE OF YOUR HEALTH INFORMATION - (CONTINUED)

Marketing

We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

Change of Ownership

In the event that The Spine and Health Center of Montvale, PC is sold or merges, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. The Spine and Health Center is not required to agree to the restriction. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.

Office Treatments

This office uses both open and closed room adjusting and therapy. Per request, we will accommodate you to a closed room for adjusting and therapy.

Changes to this Notice of Privacy Practices

The Spine and Health Center of Montvale, PC reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Dr. Wohl at 201-746-6577. If Dr. Wohl is not available, you may make an appointment to meet with him in person or via telephone within two working days.

Complaints

Complaints about how The Spine and Health Center of Montvale has handled your health information should be directed towards Dr. Wohl at 201-746-6577. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave, S.W.; Room 509F HHH Building; Washington, D.C. 20201.

Patient Name *(Please Print)*

Patient Signature **Date**

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TO OUR VALUED PATIENTS:

Due to changing Governmental Regulations, we are required to gather additional information for all patients. Please answer the following questions. **ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL**.

Thank you for your cooperation,

The Spine and Health Center of Montvale

Full Name: _____ **Date of Birth:** _____

Race *(select one)*:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

Height: _____

Weight: _____

Ethnicity *(select one)*:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Island
- ☐ Some other Race
- ☐ White

List of All Allergies:

_____

_____

_____

_____

_____

_____

_____

Alcohol Consumption *(select one)*:

- ☐ None
- ☐ Yes _____ # of drinks per day
- ☐ Occasional/Social

Do you Smoke Cigarettes?

- ☐ Yes
  - _____ # of Packs per Day
  - _____ # of Cigarettes per Day
- ☐ No

Did you ever smoke cigarettes?

- ☐ Yes
  - From when: _____
  - To when: _____
- ☐ No

Patient Signature _____ **Date** _____

****Please make sure you fill out this form in its entirety and return to our office.****