Patient Information and Condition Form

Date_____

Name_____

Address_____

City_____State_____Zip_____

Date of Birth_____Age_____ Sex: M F

Social Security # (for insurance purposes only) _____

Emergency Contact & Phone#_____

Name of Spouse or Guardian) if minor) _____

Your Occupation_____

Home Phone_____Work Phone_____

Cell Phone_____E-Mail_____

Who is your Primary Care Physician (PCP)? _____

Where is your PCP located? _____Phone_____

How did you hear about us? _____

If you find our facility on the internet, please indicate where and how (example: Google, Facebook, searched for back pain_____

Do you have health insurance: Yes No

Insurance Company Name: _____

Name of Subscriber:_____

Relationship to Patient (self) (spouse) (parent) _____

Subscriber Date of Birth_____

Subscriber Social Security #:_____

Insured ID #_____Group #_____

List your chief complaints in order of severity:

1._____For how long_____

Cause: _____

2._____For how long_____

Cause: _____

3._____For how long_____

Cause: _____

Auto Accident? Y N Work Related? Y N

Have you had two or more falls within the past 12 months? Yes No

Have you had one fall with injury within the past 12 months? Yes No

Have you had any type of diagnostic test for your chief complaint? If yes, please indicate where and date of test:

X-Ray_____ EMG_____

MRI_____ Other_____

Have you received any prior medical treatment? Please indicate when and for how long you received treatment:

Physical Therapy_____

Acupuncture_____

Chiropractic_____

Any type of injection_____

Other_____

Circle any activities that aggravate the condition:

Walking lifting coughing sitting bending sneezing sleeping standing other

Circle any activities that alleviate the condition:

Rest standing heat exercise lying down ice sitting standing massage other

Do you currently have, or have you had any of the following conditions or symptoms?

____Headaches	____Heart Condition	____Cancer
_____Knee pain	____High Blood Pressure	____HIV
_____Neck pain	____Shortness of Breath	____Dizziness
_____Low Back Pain	____Loss of smell/taste	____Depression
____Hip Pain	____Numbness/Tingling	____Anxiety
____Fatigue	____Osteoporosis	____Shoulder Pain
____Vertigo	____Stomach Problems	____Scoliosis
____Wrist or Hand pain	____Ringing in Ears	____Other
____Chest pain	____Loss of Balance	

List any hospitalizations, operations, and /or serious illnesses:

_____

_____

_____

_____

_____

_____

_____

_____

_____

List all medications you are currently taking:

_____

_____

_____

_____

Please list any allergies:

_____

_____

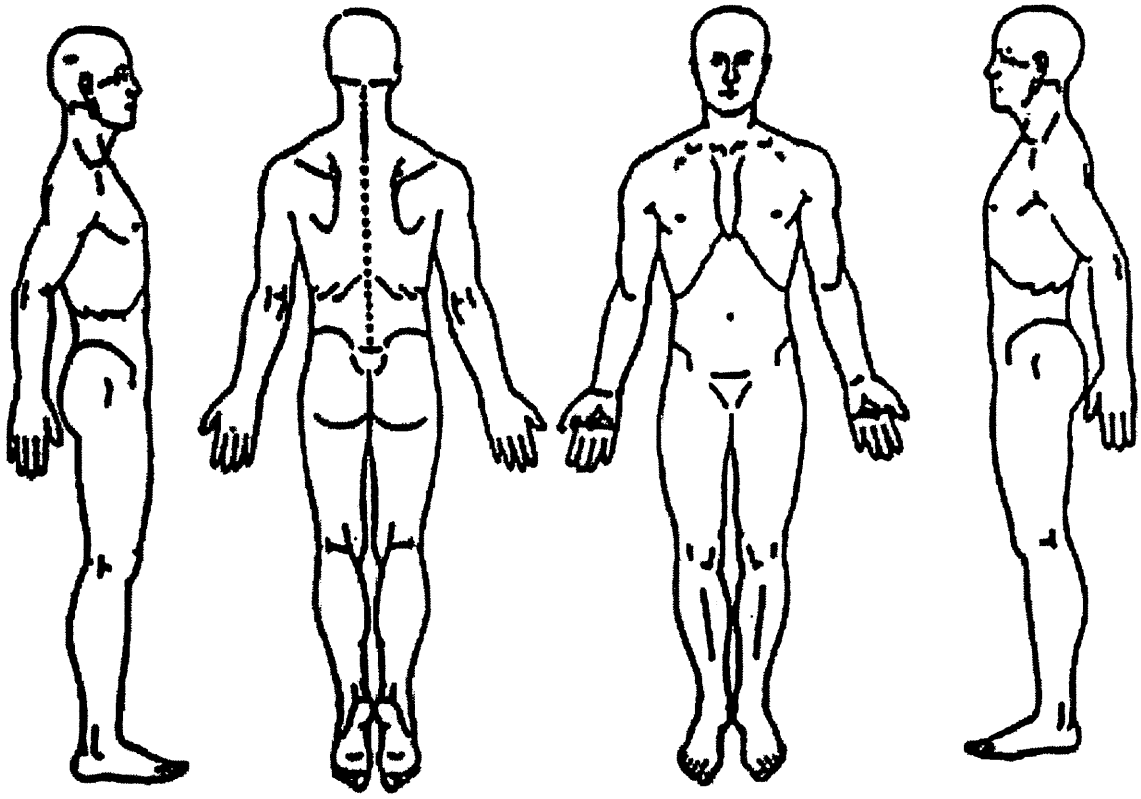
_____

_____

Please indicate if you are interested in the following wellness options:

Foot Orthotics Y N

Medical Weight Loss Y N



Please indicate on the diagram where you are experiencing pain

Does your pain travel? Yes No If yes, please draw this on the diagram

Do you have numbness/tingling in your arms, hands, legs, or feet? If so, please mark on the diagram where you are experiencing these symptoms by writing Numbness or Tingling

What is the severity of your problem? (You may also write numbers on the diagram if you prefer)

(Best) 1 2 3 4 5 6 7 8 9 10 (worst)

How are your symptoms affecting your lifestyle? (I.e. job, relationships, recreational activities, household chores)

_____

_____

_____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorneys' fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits for me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date_____

Signature of Parent or Guardian if a patient is a minor_____ Date

Date: _____

Dear Insurance Carrier:

I, _____, am currently receiving chiropractic care / physical therapy services at ***Core Spine & Wellness***.

Please know that this care is ***not related*** to any auto accident, workers' compensation injury or any other type of injury, which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this office. If you have any questions, do not hesitate to contact me personally.

My medical condition/illness is

_____.

_____

Signature

COORDINATION OF BENEFITS REQUIRED FROM MEMBER IN WRITING

If spouse in unemployed, check here____.

If working spouse does not have medical, dental, RX, or optical, ***written verification is required from their employer.*** If spouse has medical, dental, optical or RX coverage, attach copies of all ID cards, front and back.

Is your spouse disabled under Social Security Disability? YES___ NO___

Does your spouse have Medicare? YES___ NO___

Does your spouse have Medicaid? YES___ NO___

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this office. If you have any questions, do not hesitate to contact me personally.

_____

Print Name

_____ _____

Signature Date

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZATION FORM
Frank Spano, DC / Core Spine & Wellness

Financial Responsibility
I have requested professional services from Frank Spano, DC / Core Spine & Wellness on behalf of myself and/or my dependents, and understand that by making this request; I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Frank Spano, DC / Core Spine & Wellness I certify that the health insurance information that I provided to Frank Spano, DC / Core Spine & Wellness is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Frank Spano, DC / Core Spine & Wellness / CB&C to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Frank Spano, DC / Core Spine & Wellness in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Frank Spano, DC / Core Spine & Wellness directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Frank Spano, DC / Core Spine & Wellness, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Frank Spano, DC / Core Spine & Wellness upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to Frank Spano, DC / Core Spine & Wellness.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Frank Spano, DC / Core Spine & Wellness are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Frank Spano, DC / Core Spine & Wellness / CB&C to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Frank Spano, DC / Core Spine & Wellness / CB&C, INC. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Frank Spano, DC / Core Spine & Wellness and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

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

_____ _____

Patient - Print here and sign above Date

_____ _____

Policyholder/Insured Date

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____
Insured Name_____ Policy ID#_____ Relation to Insured_____

PLEASE SELECT FROM SECTIONS BELOW & CHECK ONLY *ONE* STATEMENT THAT APPLIES TO YOUR INSURANCE COVERAGE – YOU MUST SIGN THAT SECTION:

Self:

_____ I am the patient AND the insured AND I have no other insurance coverage

_____ _____
Authorized Signature Date

Spouse / Partner:

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage - the following is my coverage information:
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child (In school): (covered under parent's policy)

_____ I am a student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a student & have 2 polices. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child Under (Not in school): (covered under parent's policy)

_____ I am a dependent on the policy and only covered under this policy :
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a dependent and covered under two policies :
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Revised 5/12/13

Medical Information Release Form (HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.
This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.