



New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data:

First Name: _____ Last Name: _____ Date: _____
Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____ (Cell) _____
Referred by: _____
Age: _____ Birth Date: ____/____/____ Social Security #: _____ - _____ - _____
Occupation: _____ Employer: _____
Marital Status: _____ Spouse's Name: _____
Spouse's Employer: _____ Spouse's Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Current Complaints:

Please describe Current Complaints: _____

Was this the result of an injury? ____ Yes ____ No
Nature of Injury: ____ Automobile ____ Work ____ Other
Date of Injury: _____ Date Symptoms Appeared: _____
Have you ever had same condition?: ____ Yes ____ No
List of other practitioners you have seen for this condition: _____
Have you ever been under chiropractic care? ____ No ____ Yes, Where? _____
Have you ever been under the care of Physical Therapist? ____ No ____ Yes, Where? _____

Insurance Information:

Do you have health insurance: ____ No ____ Yes Name of Company: _____
Insurance ID# _____ Group# _____
Primary Cardholders Name _____ DOB _____ Relation to Patient: _____
Name of party responsible for payment: _____ Relation to Patient: _____
Address: _____ Phone: _____

***If auto accident, please provide:**

Auto Insurance Company Name: _____ Contact Person: _____
Phone: _____ Claim #: _____

I, _____, certify that I and/or my dependent(s) have insurance coverage
(Name of Patient)

with _____ and assign directly to Total Rehabilitation and Sports Medicine,
(Name of Insurance Company(ies))

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Total Rehabilitation and Sports Medicine may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patients signature: _____ Date: _____

Spouses or guardians signature: _____ Date: _____

Medical History:

Date of last physical exam: _____ Is there a chance that you are pregnant: ___ No ___ Yes

Have you had X-rays or MRI taken?: ___ No ___ Yes If Yes, where? _____

Please list current medications: _____

Any allergies to medications? _____

What vitamins, minerals, or herbs do you currently take? _____

Have you ever:

Briefly Explain:

Fractured a Bone? ___ No ___ Yes _____

Been in an auto accident? ___ No ___ Yes _____

Had sprains/strains ___ No ___ Yes _____

Had Surgery? ___ No ___ Yes _____

Sports Injuries ___ No ___ Yes _____

Family History:

Family Members – Present and past health conditions (example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day? ___ No ___ Yes

Do your symptoms interfere with daily life? ___ No ___ Yes

Does pain wake you up at night? ___ No ___ Yes

Are your symptoms worse during certain times of the day? ___ No ___ Yes

Do changes in weather affect your symptoms? ___ No ___ Yes

What activities aggravate your symptoms? _____

Habits:

None Light Moderate Heavy

Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____

Have you ever suffered from:

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck Pain or Stiffness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Numbness/Tingling in Arm/Hand |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Numbness/Tingling in Leg |
| <input type="checkbox"/> Cardiac Disease/Conditions | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Sleep Problems or Insomnia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Hot Flashes | |
| <input type="checkbox"/> Irregular Heart Beat | |

COORDINATION OF HEALTH BENEFITS

I, _____, am currently receiving medical care, chiropractic care, or physical therapy at TRSM. Please know that this care is *not related* to any auto accident, workers compensation injury or any type of injury, which would render a third party liable for these bills.

Name of patient _____ SS# _____ DOB _____

Insured Name _____ Policy ID# _____ Relation to Insured _____

PLEASE CHOOSE SECTION THAT APPLIES & CHECK ONLY 1 LINE

Spouse/Partner:

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

_____ 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 multiple coverage - the following are my coverages:

Primary Ins. _____ Insurance Name _____ Insured DOB _____

Secondary Ins. _____ Insured Name _____ Insured DOB _____

Signature

Date

Dependent Child Over 18: (covered under parent's policy)

_____ I am a FT student & have 1 policy.

Primary Ins. _____ Insured Name: _____ Insured DOB: _____

_____ I am a FT student & have 2 policies.

Primary Ins. _____ Insured Name: _____ Insured DOB: _____

Secondary Ins. _____ Insured Name: _____ Insured DOB: _____

**determining primary/secondary is usually based on the "birthday rule"

Signature

Date

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy:

Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a minor dependent and covered under two policies:

Primary Ins. _____ Insured Name: _____ Insured DOB _____

Secondary Ins. _____ Insured Name: _____ Insured DOB _____

**Determining primary/secondary is usually based on the "birthday rule."

Parent or Guardian Signature

Date



TOTAL REHABILITATION & SPORTS MEDICINE, LLC

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TOTAL REHABILITATION AND SPORTS MEDICINE, L.L.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Total Rehabilitation and Sports Medicine, L.L.C. (TRSM)** to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and health care operations (**TPO**). (The Notice of Privacy Practices provided by TRSM describes such uses and disclosures more completely)

I have the right to review the Notice of Privacy Practices prior to signing this consent. TRSM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Total Rehabilitation and Sports Medicine, 380 Foothill Road, Bridgewater NJ, 08807**.

With this consent, **TRSM** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **TRSM** may mail to my home or alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that TRSM restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **TRSM** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, TRSM may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print name of Legal Guardian (If applicable)



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 TRSM 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.



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Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, **Total Rehabilitation and Sports Medicine** and all medical professionals, including physician assistants of this practice, including but not limited to **Dr. Brinda Kantha, Dr. Kenneth Kearstan, and Dr. Vanessa Burns**, (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws., of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for service rendered from the provider (s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. **I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.**

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee health benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitted evidence, (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print name of Legal Guardian (If applicable)