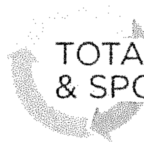

TOTAL REHABILITATION
& SPORTS MEDICINE, LLC

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	Former
Alcohol	_____	_____	_______	_____	
Coffee	_____	_____	_______	_____	
Tobacco	_____	_____	_______	_____	_____
Drugs	_____	_____	_______	_____	
Exercise	_____	_____	_______	_____	
Sleep	_____	_____	_______	_____	

Have you been diagnosed with any of the following:

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

What is your current:

Height: _______ Weight: _______

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 Pain Care under one roof

TOTAL REHABILIATION 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.

Total Pain Care under one roof

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 herby 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 an 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)

TOTAL REHABILITATION AND SPORTS MEDICINE CANCELLATION/NO-SHOW POLICY

When we make your appointment at Total Rehabilitation and Sports Medicine (TRSM), please understand that we are reserving a specific time for you to see a provider. This courtesy makes it possible for us to give you the best individual service. Late cancellations and/or no-show appointments are unfair to other patients who could be offered that appointment slot.

Effective, January 1, 2022, TRSM will charge $25.00 for any missed appointment or cancellations made with less than 24 hours notice.

We understand that from time to time situations arise in which you must cancel your appointment with less than 24 hours notice. Therefore, TRSM will permit 2 late cancellations or missed appointments before charging a fee.

Additionally, TRSM reserves the right to not see a patient who arrives more than 10 minutes late for a scheduled appointment.

It is our hope that our patients understand that arriving on time and keeping scheduled appointments helps us to give all our patients the high level of treatment and service we are known for.

______________________________ _______________

Patient Signature Date

PATIENT CREDIT CARD ON FILE AGREEMENT

Total Rehabilitation and Sports Medicine has implemented a policy to maintain your credit card information on file for the payment of outstanding balances. **Credit cards will only be charged for balances older than 60 days** unless directed by you to pay balances prior to 60 days. This is no way compromises your ability to dispute a charge.

You will continue to receive a monthly bill for outstanding balances which you may choose to pay by cash, check or credit card.

Co-pays: Co-pays are due at the time of the office visit.

Outstanding Balances: If your insurance provider has paid their portion of your bill (or the bill of any other patient you have listed on this form) and there is an outstanding balance owed, Total Rehabilitation and Sports Medicine will notify you by phone or by mail. You will receive one (1) monthly bill. If by the second bill, we have not received your payment in full (or your written dispute of the bill), any balance owed will be charged to your credit card. A copy of the charge will be sent to you by mail.

Out of Network Provider Payments: Insurance companies that Total Rehabilitation and Sports Medicine are out of network with will sometimes send payment of services directly to you. If this happens, you will be given 30 days to forward the endorsed check to us. If we have not received payment in full within 60 days, your credit card will be charged for the outstanding balance. A copy of the charge will be mailed to you.

Multiple Patients: This card will be authorized to be charged for me as well as any other person listed below:

NAME	RELATIONSHIP TO CARDHOLDER

I, ______________________________, authorize Total Rehabilitation and Sports Medicine to charge co-pays, outstanding balances and out of network payments to the following credit card:

VISA ________ **MASTERCARD** ________ **AMERICAN EXPRESS** ________ **DISCOVER** ________

CARD NUMBER: ______________________________ **EXPIRATION DATE:** ________________

CVV: ____________ **CARDHOLDERS NAME:** ______________________________

______________________________ ____________________

SIGNATURE **DATE**