Old Bridge Spine & Wellness Center

Date ____ / ____ / ____

144 Route 34, Matawan, NJ 07747
Chiropractic, Physical Therapy, Acupuncture

CASE HISTORY

Name: ________________________ DOB: _______________ Home #: _________________ Cell #: ___________________

Address: _____________________________ City: ________________________ State: _________ Zip: _________________

Email Address: ___________________________________ Primary Care Physician: _________________________________

Referred By: _______________________________ Doctor's Name: ____

Occupation: __________________________ Employer: ______________________________ Work #: _________________

Emergency Contact: _________________________ Relationship: ______________________ Phone #: _________________

Insurance Co. Name: ______________________________ Insurance ID #: ____

SS#: ___________________________ Driver's License #: ____

Spouse's Insurance Co. Name: __________________________________ Insurance ID #: ____________________________

Spouse's SS#:_________________________________ Spouse's Phone #: ____

Occupation: __________________________ Employer: ______________________________ Work #: _________________

Are present problems due to an injury: ☐ No ☐ Yes ☐On Job ☐Auto Accident ☐Personal Injury Other:_____________

Has the accident been reported: ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐Other: ____________________________

Have you retained an attorney: ☐No ☐ Yes Name & Address: ____

Chief complaints 1. _________________ Duration: ____________________ Previous Episodes: ____________________

2. _________________ Duration: ____________________ Previous Episodes:_____________________

3. _________________ Duration: ____________________ Previous Episodes: ___________________

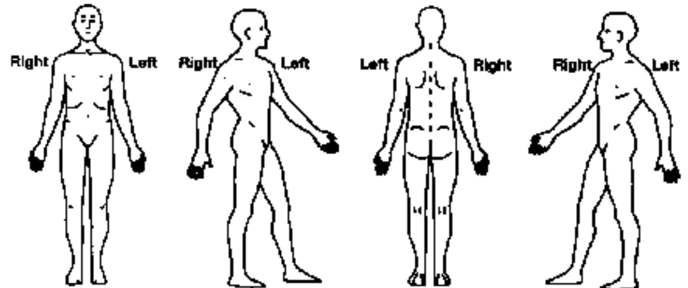
Please mark the intensity of your pain today.

1- No Pain
10- Most Intense Ever Felt

Neck
Example 1 2 3 4 5 6 7 8 9 10
1. ________ 1 2 3 4 5 6 7 8 9 10
2. ________ 1 2 3 4 5 6 7 8 9 10
3. ________ 1 2 3 4 5 6 7 8 9 10

Please mark area & type on the drawing using the listed codes below

N – Numbness T – Tingling S – Soreness
P – Pain A- Ache ST – Stiffness



Habits	Exercise	Family Histoy					
			Diabetes	Heart	Kidney	Cancer	Back
☐ Smoking Packs/Day: ______	☐ None	Mother	☐	☐	☐	☐	☐
☐ Drinking Alcohol: ________	☐ Moderate	Father	☐	☐	☐	☐	☐
☐ Coffee Cups/Day:_______	☐ Daily	Brother	☐	☐	☐	☐	☐
	Type:_______________	Sister	☐	☐	☐	☐	☐

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Patient Name: ____ DOB: _____________________________

Reason for your visit: ____

Medical History

	Yes	No	
Hypertension	☐	☐	
Hypotension	☐	☐	
Pacemaker	☐	☐	
Emphysema/Asthma	☐	☐	
Diabetes	☐	☐	
Hypoglycemia	☐	☐	
Cancer/Tumor/Growths	☐	☐	
Active Seizure Disorder	☐	☐	
Osteoporosis	☐	☐	
Swelling of Extremities	☐	☐	
Fractures	☐	☐	Where? / Date: _________________________________
Artificial Joints	☐	☐	
Lightheadedness/Dizziness	☐	☐	
Anxiety/Panic Attacks	☐	☐	
Depression	☐	☐	
Alzheimer’s	☐	☐	
Shortness of Breath	☐	☐	
Chest Pain/Angina/Heart Attack	☐	☐	
Urinary Urgency/Insentience	☐	☐	
Are you pregnant?	☐	☐	
Have you had/have…			
Spinal Cord Injury	☐	☐	
Multiple Sclerosis	☐	☐	
Brain Injury	☐	☐	
Recent falls in the past 6 months?	☐	☐	
Unexplained weight loss?	☐	☐	

Other: ____

Location of Pain: ____

Allergies: ____

Recent Surgeries (within the last 6 months): ____

Current Medications: ____

Patient’s / Guardian Signature: ____ Date: _________________________

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Patient Request for Records

Patient Name: ____

Patient Signature: ____

Date: ____

To: ____
Doctor/Hospital

Address: _______________________________________

City: ____ State: _____________ Zip: ____________

I hereby authorize the release of my ____

Or copies of such date from: ___________________________ to ________________________________ and

Request that they be transferred to: ____

Dr. Peter Bufano
Old Bridge Spine & Wellness Center
144 Route 34
Matawan, NJ 07747
T: 732-316-5895 l F: 732-316-5894
www.oldbridgespine.com

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Notice of Privacy Practices

This notice describes how medial information about you may be used and disclosed and how you can get access to this information: Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographics, that may identify you and that relates to your past, present, and future physical and medical health or conditions that relate to health care services.

We ae required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that revised copy be sent to you in the mail or asking one at the time of your next appointment.

Uses and Disclosures of Protected Health Information:

Uses and disclosures of Protected Health Information based upon your written consent:

You will be asked by your chiropractor/physical therapist/acupuncturist to sign consent form(s). Once you have consented to use and disclosure of your protected health information for treatment, payment of health care operations by signing the consent form. Your chiropractor/physical therapist/acupuncture will use or disclose your protected health information as described in this section. Your protected health information may be used and disclosed by your chiropractor/physical therapist/ acupuncture, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's office.

Healthcare Operations:

We may use of disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality of assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to chiropractic/physical therapy/acupuncturist students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your chiropractor/physical therapist/acupuncturist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you for your appointment. We will share your protected health information with third party "Business Associates" that preforms various activities (e.g. billing, transcriptions services) for the practice. Whenever as arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have written contract that contains items that will protect the privacy of your protected heal information.

We may use or disclose your protected health information as necessary to provide you with information about your treatment alternatives or other health related benefits and services that may be of interest to you. We may also useand disclose your protected health information for chiropractor/physical therapist/acupuncturist marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the service we offer. We may also send information about products or services that we believe may be beneficial to you. You may contact or office to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your chiropractor/physical therapist/acupuncturist, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Following are some types of use and disclosures of your protected health care information that the office is permitted to make once you have signed consent forms.

Treatment, Payment, Healthcare Operations, Others involved in your Healthcare, Emergencies, Communication Barriers:

Other permitted and required uses and disclosures that may be without your consent, authorization, or opportunity to object, we may use or disclose your protected health information in the following situations without your consent or authorization includes:

Required by Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, and Inmates.

Required use and disclosures under the law, we must make disclosures to you and when required by the secretary of Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500 et. Seq.

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Your Rights:

You have the right to inspect and copy your protected health information. This means you inspect and obtain a copy your protected health information about you that is contained a designed record set for as long as we maintain the protected chiropractor/physical therapist/acupuncturist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, of use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances; you may have this decision reviewed. Please contact our office if you have any questions about access to your medical records

You have the right to request a restriction of your health information. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You may have the right to have your chiropractor/physical therapist/acupuncturist amend your protected health information. You have right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to obtain a paper copy of this notice form from us upon request. You have the right to complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with use by notifying our office of your complaint. We will not retaliate against your for filing a complaint.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I understand that as a part of my healthcare, this organization originates and maintains records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment
A means of communications among the many health professionals who contribute to my care
A source of information for applying my diagnosis surgical information to my bill
A means by which a third-party prayer can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing quality and reviewing the competence of professionals

I understand and have been providing with Notice of Information Practices that provides a more complete description of information and disclosures. I understand I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a cop of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already take action in reliance thereon. I request the following restrictions to the use of disclosure of any health information.

I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described in the notice of information practices.

Signature of Patient or Legal Representative ____________________ Witness ____________________

Date ____________________ Notice of Effective Date ____________________

☐ Accepted ☐ Denied

Signature ____________________ Title ____________________ Date ____________________

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Insurance and Billing Policies

INSURANCE: Old Bridge Spine and Wellness will gladly submit your claims to insurance carriers. In order to do so, we need your cooperation. Complete and current insurance information is required in order for our office to submit a claim to your primary insurance plan. This information needs to be provided at EACH visit or you may be required to reschedule or make payment at the time of service. It is the patient's responsibility to notify Old Bridge Spine and Wellness of any changes in or termination of their insurance. If using a parent's insurance, the patient must sign accepting financial responsibility if not covered with the EXCEPTION of minors. Old Bridge Spine and Wellness is an out of network practice and will bill as such. HRA plan payments are subject to the insurance carries discretion, rates will be paid at a UCR out of network rate.

REFERRAL/AUTHORIZATIONS: It is the patient's responsibility to make sure that the referral has be obtained from their Primary Care Physician and to bring a copy of that referral to our office. If you do not have a referral you may be asked to reschedule your appointment or you may choose to pay in full for services that day.

CO-PAYS, COINSURANCE, AND DEDUCTIBLES: Co-pays are fixed amounts that your insurance plan has designated as your responsibility for each office visit. This amount may be collected prior to your office visit, unless there are prior arrangements made waiving the co-pay for that day. If coinsurance or deductible is applied to you responsibility instead, you may be billed for the additional amount once your insurance processes the claims or prior arrangements have been made.

MEDICARE: Our doctor's and physical therapists are participating with Medicare part Band will bill for services provided. You will be responsible for any deductible or co-insurance. We will submit to a secondary insurance as a courtesy. If payment is not received within 60 days, you will be billed for the amount owed as per Medicare. If you would like to submit your secondary insurance, we will gladly issue you a receipt for services rendered.

WORKER'S COMP & MOTOR VEHICLE ACCIDENTS: We will bill the insurance carrier directly. You are responsible for providing the complete claim information, claim address, and adjuster's contact information. If your worker's comp or PIP insurance denies your claim, we will bill your medical insurance if the appropriate information or referrals needed were provided in a timely manner. We will await result of any litigation to receive payment. We do accept "Letters of Protection". You will not be billed for any patient co-insurance, deductibles, or if claims are denied during treatment provided "Old Bridge Spine and Wellness agreement is signed".

SELF PAY: If you do not have medical insurance coverage payment as per Old Bridge Spine and Wellness fee schedule is required at time of service.

AUTHORIZATIONS: Prior authorizations are required by some insurance for certain services whether provided in or office, hospital, or at a radiology facility. Patients should know their insurance plan and should advise front desk personnel that authorizations required prior to your visit. We will gladly submit the authorization for you. If authorization is not given prior to date of service you may have to reschedule and or pay in full for services that day.

Cancellation Policy: If you fail to call and cancel your appointment 24 hours prior, we reserve the right to bill you a cancellation fee of $25.00.

Returned Checks: If a check you issued as payment is returned by your bank (for any reason) you will be charged a fee of $20.00. Any future payments to our office may be required to pay cash or credit/debit card ONLY.

I have read and understand the above policy regarding my financial responsibility to Old Bridge Spine & Wellness. My failure to fulfill my financial obligation may cause interruption or delays in my care.

Print Patient Name: ____

Patient Signature: ____ Date: ________________________

INFORMED CONSENT

Patient, please discuss any questions or concerns with the Chiropractor, Physical Therapist, or Acupuncturist *before* signing this consent.

I hereby irrevocably request and consent through the appropriate personnel, to furnish medical care and treatment to me, or the patient named below, considered necessary and proper diagnosing or treating my physical condition. I consent to the performance of chiropractic adjustments/procedure, physical therapy procedures and acupuncture procedures.

I have had the opportunity to discuss with the doctor and/or other clinical staff personnel the benefits of the procedures and other treatments outlined below. Alternatives to treatment have been reviewed.

Chiropractic Care: Through chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am fully informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disk injuries, strokes, dislocations, and sprains.

I understand that chiropractic/physical therapy/acupuncture is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic/physical therapy/acupuncture treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I irrevocably consent to the proposed treatment.

All Patients: The Following OFFICE POLICY Applies:

- You the patient are financially responsible for any procedures, treatments, supplies and or office visits by this office to you and your care.
- In the event of accepting your insurance on assignment, we have to wait for payment; this courtesy may be withdrawn if any circumstances warrant it.
- We will bill your insurance company on a 30 day cycle as long as you are receiving chiropractic, physical therapy, or acupuncture treatment in this office.
- You are required to sign an “Authorization to Pay Physician/Clinician” form and any other assignment documents required by your insurance company on your first visit.
- Your office does NOT guarantee that your insurance company will pay. We will make every attempt at the beginning of your healthcare to receive verification of your policy and what it covers. However, if for some reason your insurance claims are denied, you are responsible for the full amount of the bill.
- Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company.
- It must be fully understood that the contract between YOU and YOUR insurance company and YOU are responsible for any amount not paid by your insurance company
- Should your insurance company request written reports regarding your condition or progress similar information, there will be an additional fee.
- OLD BRIDGE SPINE & WELLNESS CENTER, reserves the right to pursue any delinquent claims in any mannerism deemed necessary.
- If you are unable to keep your appointment, 24 hour advance notice must be giving or normal charge will prevail.

Print Patient Name: ____

Patient Signature: ____ Date: ________________________

Assignment of Benefits

Patient: __________________________________

Insurance: __________________________________

Claim#/SS# __________________________________

I hereby authorize the _________________________________Insurance Company to pay by check made out and mailed to:

Old Bridge Spine & Wellness Center
144 Route 34
Matawan, NJ 07747

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above tis insurance payment.

I also hereby assign to Old Bridge Spine & Wellness, all of my rights to obtain payment under the personal injury protection provisions of an automobile insurance policy or any other health insurance policy of any medical bills incurred as a result of my treatment, including the option to submit any dispute in my name to binding arbitration under the auspices of the American Arbitration Association or any other form that the provider deems appropriate.

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

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involve in this case.

Date: ______________________________

____
Signature of Policyholder

____
Signature of Claimant, if other than Policyholder

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Cancellation Policy

Dear Patient,

This is to remind you that the office will be reinforcing our 24 hour cancellation and missed appointment fee policy. If you must cancel your scheduled appointment it must be done prior to 24 hours. Otherwise a fee of $25 will be charged. Last minute cancellations and missed appointments cause significant scheduling conflicts with the other patients who prefer those scheduled times. We appreciate your cooperation in this manner. Thank you

Sincerely,

Old Bridge Spine & Wellness Center

Print Patient Name: ____

Patient Signature: ____ Date: ____________________

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MEMBER AUTHORIZATION FORM FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

To: ____

____

____

Date: ____

Member Name: ____

Member Number: ____

I hereby authorize Old Bridge Spine & Wellness, P.A. to appeal my plan administrator's determination on my behalf, as my Authorized Representative, and, as a part of the appeal, I hereby authorize my health plan administrator in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> A copy of my Summary Plan Description (SPD) and description of the Plan's Claim Appeal Procedure for the subject period, as well as all medical and financial information contain in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder, and HIV status relating to m examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of six years unless otherwise limited by the plan or the governing law.

____
Signature of Member (Patient) or Legal Guardian/Representative

____
Signature of Designated Representative

____ ______________________________________
Name of Designated Representative Title

Old Bridge Spine & Wellness Center
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Thank you for choosing Old Bridge Spine and Wellness Center, “A center of excellence for physical medicine and rehabilitation.” Our rehabilitation team will be working closely with you to ensure you receive maximum health wellness while you are under our care. Our philosophy is, your goals are our goals and together we can achieve them.

Please list the following three physical goals as well as the three wellness goas you would like to reach during your care with us. Once this form is completed, we will tailor a program that is specific to only you which will be built around your wants and needs. Again, than you for entrusting us and we look forward to getting you back to optimal health.

Physical Goals

(i.e. walk ½ mile without pain, lift my children, play sports, ect)

1. ____

2. ____

3. ____

Wellness Goals

(i.e. take vitamins, eat more fruits and vegetables, eat more home cooked meals, ect.)

1. ____

2. ____

3.____

Yours in health,

Dr. Peter Bufano
Rehabilitation and Wellness Director