Fischer Health & Rehab
413 King George Road, Suite 205 • Basking Ridge, NJ 07920 • Phone: 908.903.1901 • Fax: 908.903.1902

New Patient Health History Form

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

Patient Data

Name _____ Date _____

Email (For our office use only) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Age _____ Sex _____ Birth Date _____ Social Security # _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____

Emergency Contact/Relationship _____

Who May We Thank For Referring You? _____

Previous Chiropractic or Physical Therapy Care? ☐ Yes ☐ No

If yes, please describe _____

Insurance Information

Health Insurance Company _____ Phone _____

Subscriber _____ Subscribers Employer _____

Policy # _____ Group # _____

Auto Claim Ins. Co. _____ Contact Person _____

Phone _____ Claim # _____

Name of the insured _____

I understand and agree that the health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____

Spouse's or Guardian's Signature _____

Current Complaints

Nature of Injury: Automobile ☐ Work ☐ Other ☐ _____

Please Describe _____

_____

Date of Injury _____ Date Symptoms Appeared _____

Please describe complaint and how it began _____

_____

When did this begin? _____

What makes it feel better? _____

What makes it feel worse? _____

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Current Complaints (Continued)

Is it traveling anywhere (down legs, etc?) _____

How often is it present? Constant (81-100%) Frequent (51-80%) Occasional (26-51%) Mild (25% or less)

Have you been treated for this condition with another Doctor or Therapist? ☐ Yes ☐ No

If so whom? ☐ MD ☐ Chiropractor ☐ Physical Therapist ☐ Other

What treatments have you received? _____

How much is this effecting your daily activities?

0 1 2 3 4 5 6 7 8 9 10

Not at all Severely

Medical History

Have you been treated for any conditions in the last year? ☐ Yes ☐ No

If yes, please describe _____

Date of last exam _____ Is there a chance you are pregnant? ☐ Yes ☐ No

Major Surgery/Operations _____

Major Accidents or Falls _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc.) _____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosages, and frequency).

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with your daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms? _____

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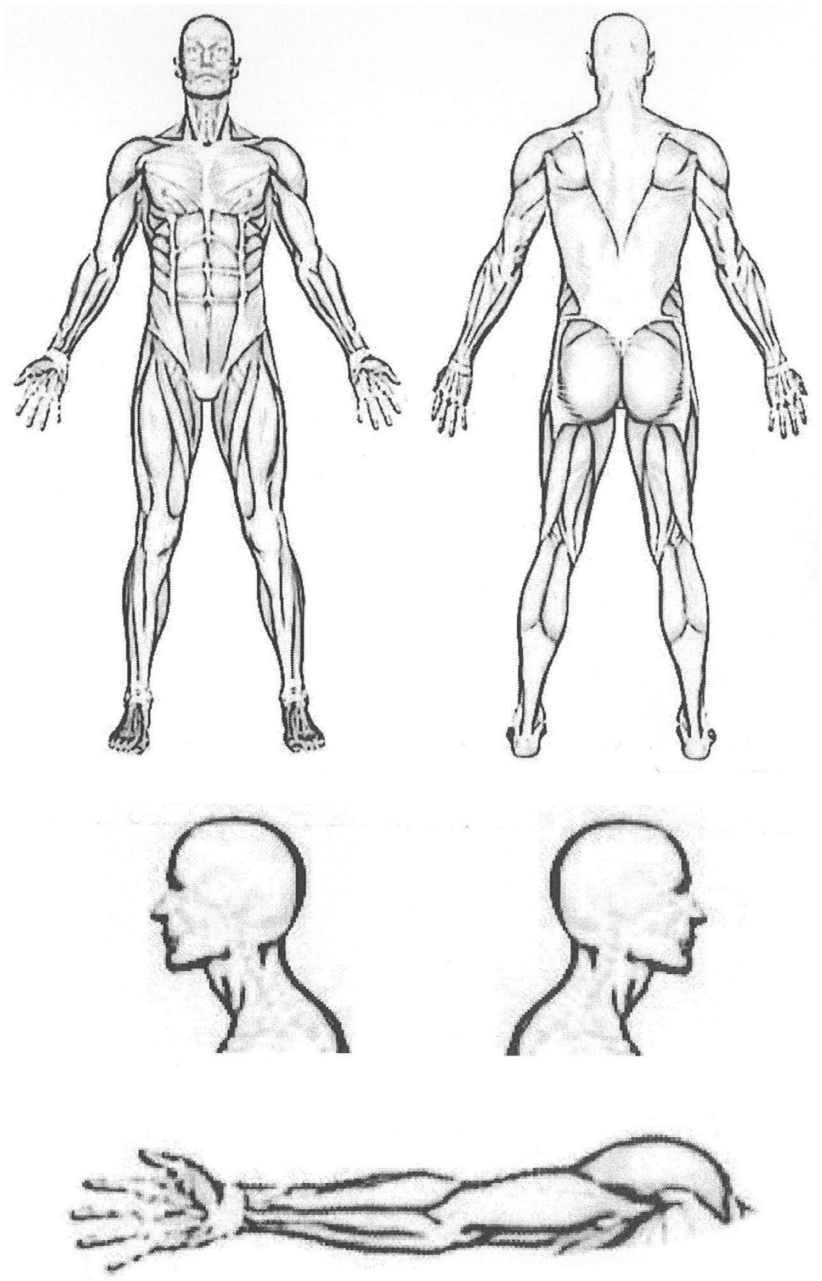
Have you ever suffered from:		Date:
Alcoholism	☐	
Allergies	☐	
Anemia	☐	
Arteriosclerosis	☐	
Arthritis	☐	
Back Pain	☐	
Breast Lump	☐	
Bronchitis	☐	
Bruise Easily	☐	
Cancer	☐	
Chest Pain/Conditions	☐	
Cold Extremities	☐	
Constipation	☐	
Cramps	☐	
Depression	☐	
Diabetes	☐	
Digestion Problems	☐	
Dizziness	☐	
Ears Ring	☐	
Excessive Menstruation	☐	
Eye Pain/Difficulties	☐	
Fatigue	☐	
Frequent Urination	☐	
Headache	☐	
Hemorrhoids	☐	
High Blood Pressure	☐	
Hot Flashes	☐	
Irregular Heart Beat	☐	
Irregular Cycle	☐	
Kidney Infection	☐	
Kidney Stones	☐	
Loss of Memory	☐	
Loss of Balance	☐	
Loss of Smell	☐	
Loss of Taste	☐	
Neck Pain or Stiffness	☐	
Nervousness	☐	
Nosebleeds	☐	
Pacemaker	☐	
Polio	☐	
Poor Posture	☐	
Prostate Trouble	☐	
Sciatica	☐	
Shortness of Breath	☐	
Sinus Infection	☐	
Sleep Problems/Insomnia	☐	
Spinal Curvatures	☐	
Stroke	☐	
Swelling of Ankles	☐	
Swollen Joints	☐	
Thyroid Condition	☐	
Tuberculosis	☐	
Ulcers	☐	
Varicose Veins	☐	
Venereal Disease	☐	
Other	☐	

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



Pain Level 0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

Patient's Signature _____

FISCHER HEALTH & REHAB HIPPA COMPLIANT FORM

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.

In the course of your care as a patient at Fischer Health & Rehab we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

If we provide health care services to you in an emergency; If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so; If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. If we are ordered by the courts or another appropriate agency;

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have any concerns, or would like further information about our privacy policies and practices please contact Dr. David Fischer. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment as described in the office's privacy notice. In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party

Personal Representative Printed	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient

Fischer Health & Rehab

413 King George Road, Suite 205 • Basking Ridge, NJ 07920 • Phone: 908.903.1901 • Fax: 908.903.1902

Assignment of Benefits

Date: _____

Patient: _____

Claim # / Group #: _____

SS # / ID #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Fischer Health & Rehabilitation
413 King George Rd. Suite 205
Basking Ridge, NJ 07920

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Fischer Health & Rehabilitation
413 King George Rd. Suite 205
Basking Ridge, NJ 07920

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 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, in a current manner, any balance of said professional service charges 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 release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

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

Dated this _____ day of _____ , 20 ____

_____
Signature of Policyholder

_____
Witness

_____
Signature of Claimant, if other that Policyholder.

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Patient Name: _____ Group No: _____
Insured Name: _____ Insured ID: _____

FH&R Indigent Policy & Agreement

Subject to Applicable Payment from HSA, FSA, MSA & HRA Account(s)

Our indigency discount is no different than all PPO discounts from all commercial insurers (such as BCBS or Aetna for example) in compliance with all applicable federal and state laws with respect to indigency assistance without any routine waiver of cost sharing, advertising, or solicitation, for underinsured or uninsured patients. **Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount**, except for all applicable payment from **HSA, FSA, MSA & HRA** account(s), without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage, based on the provider's actual total and reasonable charges in accordance with Provider's Corporate Indigency Policy, **as the Indigency determination itself is a good effort to collect**, and hospitals or doctors are NOT required under any federal or state laws, Medicare, ERISA & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bills. New federal Affordable Care Act (ACA) Uniform Glossary provides: "Deductible is *the amount you **owe** for health care services your health insurance or plan covers **before your health insurance or plan begins to pay***".

In consideration of my particular medical needs and care expenses to be incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage, **I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:**

- ☐ Middle class income, with high deductible / co-insurance, as medically indigent (see CMS Definition below)
- ☐ Middle class income, Cash Pay - without any or applicable insurance for treatment from this provider / facility
- ☐ Low or a fixed income, with financial hardship, as financially indigent

More importantly, relying upon a recent 5th Cir. Court decision in NCMC v. CIGNA, case # 12-20695, 03/10/2015 and the fact that I have no knowledge of any plan exclusion, limitation or plan language to condition coverage on the collection of 100% deductible or coinsurance, I declare that without following indigence assistance, seeking for and continuing with medically appropriate and important health care would be impossible for me or would make me indigent if I were forced to pay full charges for my medically necessary care. I also declare that I personally requested for such indigence assistance only after I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs and availability of this provider Indigency Policy. Without my expressed permission, NONE of my private financial information or documents may be released to any 3rd party TPA, except for this Indigency Agreement or only medical information as requested by my health plan / TPA.

> *"Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the healthcare provider indigency policy. By "**indigency policy**" we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By "**medically indigent**," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses."*
> *(http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf)*
>
> *"No circuit court has ruled that providers must first bill their patients before they may enforce legitimately assigned benefits claims" DOL 9th Cir. Oral Argument: http://cdn.ca9.uscourts.gov/datastore/media/2014/04/07/12-17604.wma*

I specifically request under this provider indigency policy for the following indigent discount assistance for the specific time periods from _____to _____, after determining in good faith that I am in financial need or after reasonable collection efforts failed.

☐ I can only afford to pay $_____ for my total balance ☐ I am only able to pay $_____monthly for _____ months

Patient's Signature _____**Date**_____

Staff Signature _____**Date**_____

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Our Practice Participates With:

Horizon BCBS
Newark, NJ
(800) 355-2583

Qualcare
30 Knightsbridge Rd, Piscataway, NJ 08854
(800) 992-6613

Medicare
PO Box 1270, Lawrence, KS 66044
(800) 633-4227

Facilities Our Practice Is Associated with:

Spark Medical
Dr. Joshua Persaud
1084 Main Ave., 1st Fl
Clifton, NJ 07011
(732) 267-0092

American/Advanced DME, LLC
PO Box 498
Marlboro, NJ 07746
(732) 679-2083

L & C Podiatry PC
Dr. Lenny Ramirez
413 King George Rd, Ste 205
Basking Ridge, NJ 07920
(908) 903-1901

If the patient's health plan is not listed above, the physician and/or facilities providing services do not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Licensed Assistant Healthcare Staff:
The following licensed healthcare professionals may perform assistant services on the patient based upon the treatment plan and needs of the patient:

Names:
Erin Polos (PT)
Lauren Daniels (L.Ac.)
Dr. Joshua Persaud (MD)
Biagio Cerno, PA
Dr. Lenny Ramirez (DPM, FACFAS)

Address & Phone Number:
413 King George Rd, Ste 205
Basking Ridge, NJ 07920
(908) 903-1901

Anesthesia, Radiology, Laboratory, Pathology Services:
The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

Name:
Harding Radiology

Address & Phone Number:
1201 Mt Kemble Ave, Morristown, NJ 07960
(908) 221-0603

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with the patient's health insurance plan and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact the patient's health plan or administrator for further consultation on costs associated with these services.

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan.

Out-of-Network Patients **In-Network Patients:**

Patient initials: [or] N/A:

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

3) I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures – **OUT-OF-NETWORK PATIENTS**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Sign:_____ Print Name: _____ Date: _____

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan.

Out-of-Network Patients **In-Network Patients:**

Patient initials: [or] N/A:

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

3) I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Out-of-Network Patients **In-Network Patients**

Patient initials: [or] N/A:

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures – **IN-NETWORK PATIENTS (QualCare)**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I understand that currently my out of pocket expenses will be limited to those described in my insurance policy and the contractual obligations between the health care provider and my insurance carrier. The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professionals' changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Sign:_____ Print Name: _____ Date: _____

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Disclosure of Financial Interest in Spark Medical

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, chiropractor, podiatrist and all other licenses of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service to which patients are referred:

Spark Medical, 413 King George Rd, Basking Ridge, New Jersey 07920.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in an online telephone directory or search engine under the appropriate heading.

Please sign below to acknowledge that you have been informed of the ownership interest in the above entities prior to or at the time you were referred to the above entity.

PATIENT'S NAME: _____ DATE: _____/_____/___
(Please Print)

PATIENT'S SIGNATURE: _____

Thank you for your patronage.

Sincerely,

David Fischer, DC
Spark Medical