PEDIATRIC HISTORY FORMS

In order to provide the best possible Wellness Care, please complete this form in NEAT PRINT and bring it to your first appointment. All information is strictly CONFIDENTIAL

Patient Data

Date _____

Patient First Name _____MI _____ Last Name_____ Nickname _____

Main Address _____ City_____ State ____ Zip _____

Birth Date _____ Age _____ Gender _____ Height _____ Weight _____ Social Security#_____

Pediatrician's Name_____ Phone _____ Address_____

Primary Contact for communication (i.e. upcoming appointments/ events)

Parent/ Guardian Name_____ Cell#_____ Email_____

Who do you normally live with? □ Mother and Father □ Father □ Mother □ Legal Guardian

Mother's Name _____ Cell#_____ Home#_____ Work#_____

Father's Name _____ Cell#_____ Home#_____ Work#_____

Guardian's Name _____ Cell#_____ Home#_____ Work#_____

Who May We Thank for Referring You? _____

How else did you hear about us? _____

Insurance Information

Primary Health Insurance

Company_____Phone#_____

Policy #_____ Group# _____

Subscriber's Name _____ DOB _____ Employer_____

Secondary Health Insurance

Company_____Phone#_____

Policy #_____ Group# _____

Subscriber's Name _____ DOB _____ Employer_____

Automobile Claims (if applicable)

Auto Claim Ins. Co. _____ Claim#_____

Contact Person _____ Phone# _____ Name of Insured_____

Authorization for Care of Minor: I hereby authorize health care providers at Fischer Health & Rehabilitation to administer care to my son/ daughter as they deem necessary. I am authorized to provide consent for the minor and I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Printed Name of Parent/ Guardian_____

Signature of patient or responsible party: _____ Relationship to patient: _____

Fischer Health & Rehab

PEDIATRIC HISTORY FORMS

Current Complaints

Reason for today's visit _____

_____

_____

Other Providers Seen for THIS Condition: ☐No ☐Yes, Provider's Name_____

Prior Treatments _____

Is your child experiencing pain ☐No ☐Yes, Describe_____

Medical History

Check any of the following conditions your child has had:

☐ADHD ☐Asthma/ allergies ☐Back pains ☐Bed Wetting ☐Car Accident ☐Colic ☐Concussion

☐Chronic Colds ☐Digestive Problems ☐Ear Infections ☐Growing pains ☐Headaches ☐Recurrent Fevers ☐Scoliosis

☐Seizures ☐Temper Tantrums ☐Torticollis

Other Health Problems/ Conditions ☐No ☐Yes, List _____

Family History _____

Current Medications/ Vitamins_____

_____

Allergies _____

Number of Doses of Antibiotics Your Child has Taken: _____During Past 6 months _____Total During Your Child's Lifetime

Name of Pediatrician_____ Phone _____ Address _____

Date of Last Visit __ /__ / ____ Reason_____

Vaccination History ☐up to date ☐other, describe _____

Any Adverse Reactions ☐No ☐Yes, Please explain _____

Check if had following Childhood Diseases:

Chicken Pox ☐No ☐Yes Age___ Whooping Cough ☐No ☐Yes Age___ Mumps ☐No ☐Yes Age___
Rubella ☐No ☐Yes Age___ Rubeola ☐No ☐Yes Age___

Other Significant Illnesses/Diseases ☐No ☐Yes, List _____

Females Menarche ☐No ☐Yes, Age _____

Check if seen before: ☐Chiropractor ☐Physical Therapist Date of Last visit: __ /__ / ____ Reason_____

According to the National Safety Council, approximately 50% of children FALL HEAD FIRST from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child? ☐No ☐Yes

Medical History continued

Is/ has your child been involved in any High Impact or Contact type of Sport? (Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)

High Impact/ Contact ☐No ☐Yes, List Sport(s)_____

Prior Injuries/ Trauma ☐No ☐Yes, List _____

Prior Surgeries ☐No ☐Yes, List _____

Has Your Child Ever been involved in a car accident? ☐No ☐Yes, List _____

Has Your Child Ever been seen on an Emergency Basis? ☐No ☐Yes, List _____

Prenatal History

Name of Obstetrician/ Midwife _____

Cigarette/ Alcohol Use During Pregnancy? ☐No ☐Yes

Complications During Pregnancy? ☐No ☐Yes, List _____

Medications During Pregnancy? ☐No ☐Yes, List _____

Ultrasounds During Pregnancy? ☐No ☐Yes, How Many? _____

Complications During Delivery? ☐No ☐Yes, List _____

Location of Birth: ☐Home ☐Birthing Center ☐Home

Birthing Intervention: ☐Forceps ☐Vacuum Extraction ☐Caesarian Section if yes, ☐Emergency or ☐Planned

Birth Weight _____ Birth Length _____ APGAR Scores _____

Feeding History

Breast Fed ☐No ☐Yes, How Long _____

Formula Fed ☐No ☐Yes, How Long _____ Type _____

Age introduced to: Solids at _____ months Cow's Milk at _____ months

Food/ Juice Allergies or Intolerances ☐No ☐Yes, List _____

Developmental History

During the following time your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

_____Respond to Sound _____ Hold Head Up _____ Cross Crawl _____Walk Alone

_____Respond to Visual _____ Sit Up _____ Stand Alone

FISCHER HEALTH & REHABILITATION HIPPA COMPLIANCE NOTICE

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 & Rehabilitation 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 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 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.

My signature acknowledges that I have read and have been offered a copy of this HIPPA Compliance Notice.

Printed Patient Name: _____ Date: _____

Signature of patient or responsible party: _____ Relationship to patient: _____
(i.e. Patient is minor)

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 Fischer Health and Rehabilitation is In-Network With:
Horizon BCBS Newark NJ, (800) 355- 2583
Medicare PO Box 1270, Lawrence, KS 66044 (800) 633-4227

If the patient's health plan is not listed above, the physician and/or facilities are out of network with the patient's health plan. We participate with all insurance plans except for Medicaid therefore will submit claims to your insurance company on your behalf.

The following is a list of current licensed and certified healthcare professionals that may perform services in our facility based upon treatment plan and needs of the patient:

Chiropractors: Dr. David A. Fischer, DC and Dr. Steven M. Raymond, DC
Physical Therapists: Erin Polos, PT, Kelli Short, DPT and Renee A. Fischer, PT
Acupuncturist: Lauren Daniels L. Ac
Massage Therapist:
Personal Trainer: Linda Downey

Health Care Providers Our Practice Is Currently Associated with that may provide services within our office:
Spark Medical Dr. Joshua Persaud MD and Biagio Cerno, PA 1084 Main Ave., 1st Floor Clifton NJ, 07011 (732) 267- 0092
L & C Podiatry PC Dr. Lenny Ramirez DPM, PACFAS 413 King George Rd, Ste 205 Basking Ridge, NJ 07920 (908) 903- 1901

Facilities Our Practice Is Currently Associated with:
American/ Advanced DME, LLC PO Box 498 Marlboro, NJ 07746 (732) 679-2083
Harding Radiology 1201 Mt Kemble Ave, Morristown, NJ 07960 (908) 221-0603

My initials below and by signing this form, I acknowledge understanding that I may be referred to other health care professionals or services within our office or be referred to health care professionals or facilities outside our office and understand that I may seek care or services by an alternative provider of my choosing and that I was advised I should inquire directly with each provider or health insurance company to confirm in or out of network participation status and costs. Initials: _____

Disclosure of Financial Interest in:
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.

Printed Patient Name: _____ Date: _____

Signature of patient or responsible party: _____ Relationship to patient: _____
(i.e. Patient is minor)

Financial Policy and Disclosures

1) I understand that it is my responsibility to know my insurance policy as relates to health care provider participation being in or out of network and coverage by my insurance company, to inform my health care provider of any changes to my insurance plan, and to provide a referral at the time of my office visit if needed or else I am responsible for charges incurred.
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. I understand that I am responsible to pay all co-payment at time of service. If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurance and or provider. I acknowledge that I assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services.
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.
4) I understand that I may 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.
5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs. 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.
6) I understand that if the provider is out of network, my insurance company may send the check directly to the patient. It is the patient's responsibility to sign the back of the check and return the check and all paperwork included with the check over to the provider.
7) 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 at their next visit.
8) At Fischer Health and Rehab we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, activities, snowstorms, and illness are just a few of the reasons why one might consider canceling an appointment. **In our desire to be effective with treatment and fair to all of our clients and out of consideration for our Therapist's time we require a 24 hr. notice for all cancellations. There will be a $50.00 missed/ no show fee for Physical Therapy and 50% fee will be charge for the Acupuncture and Massage Therapy.**

My initials below and signature on this form acknowledges that I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage. Initials: _____

Indigent Assistance Notice
I acknowledge that I was made aware that Fischer Health and Rehabilitation has an Indigent Assistance Notice for individuals who have extreme financial difficulty and are unable to pay for part or all expenses. *My initials below and signature on this form acknowledges that I was offered a copy of the this notice for additional information to determine indigency and that I do not need Indigency assistance.* Initials: _____

Acknowledgement of Receipt of Financial Policy and Disclosures
I, the undersigned patient, acknowledge receipt of this financial policy and disclosure form from my health care provider, and have read it and understand the contents. I have discussed if the providers are in network with my insurance plan or not and options to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may be in-network with my health plan and I waive the right to do so. I 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.

Printed Patient Name: _____ Date: _____

Signature of patient or responsible party: _____ Relationship to patient: _____
(i.e. Patient is minor)

Informed Consent for Care

Printed Patient's Name: _____

General. I, the patient, have read this document in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I understand that other treatment options for my condition with may have potential benefits and risks which may include: Self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; hospitalization, and surgery. If you chose to use on the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below. You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Chiropractic Care: As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy, and that those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare." The doctor will make every reasonable effort during examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor and update the doctor in the future**. More gentle forms of chiropractic treatment or other health care services may be proposed if spinal manipulation is not recommended.** There may be risks to going without care/ remaining untreated such as allowing the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Acupuncture: I consent to the performance of acupuncture treatments and other procedures by a licensed Acupuncturist which may include but are not limited to acupuncture moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), and Gua Sha. I hereby acknowledge I have been informed of the purpose, benefits and risks of acupuncture and other procedures and potential side effects and complications, including but not limited to dizziness, fainting, bruising which is a common side effect of cupping, and bruising, numbness or tingling near needle sites that may last a few days. Although acupuncture is considered a safe method of treatment, unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including long puncture (pneumothorax). I understand that the risk of infection is negligible when all needles are sterile and one time use.

Physical Therapy: The most common side effects of physical therapy are muscle fatigue, soreness or pain in the area where treatment was performed, difficulty sleeping as a result of muscle soreness, decreased range of motion during or after physical therapy until muscles become accustomed to the exercise temporary swelling in the area treated, burns, bruising in areas with deep tissue massage, allergic reactions to tape, topical treatments, gels and lotions. I understand the side effects are typically temporary and manageable and understand that I can help minimize those risks by communicating with the provider about any allergies and pain or difficulty with or during any interventions.

Massage: While complaints of minor side effects to treatment are normal, some more serious and/or rare problems can occur with deep tissue massage. These are some of the varying risks in undergoing deep tissue massage including aggravating an older injury, headache, fatigue, nausea from releasing tension and toxins from your body, inflammation, skin redness, bruising or feeling heat from applying pressure. The movement of muscle fibers can cause lingering pain. Naturally, your muscles may feel some soreness after a massage since this penetrates the uppermost layers of muscle. Muscles will then feel relaxed, potentially causing fatigue or muscle aches. Your therapist may advise you drinking water to flush out toxin, resting/getting more sleep should eradicate any more issues or applying ice packs to inflamed areas or taking a low dose of over the counter pain relievers to alleviate side effects. Speaking honestly with your massage therapist about allergies, any pre-existing conditions or injuries (or simply your ability to bruise easily)

My initials certify that I have read and understand regarding the above informed consent form. Initials: _____

Fischer Health & Rehabilitation 413 King George Rd, Ste 205 • Basking Ridge, NJ 07920 • Phone • 908-903-1901 • Fax 908-903-1902

Informed Consent for Care

Below is a list of Healthcare Services offered at our office in case you currently or in the future use these services. Carefully read the descriptions below.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

I hereby authorize Fischer Health & Rehabilitation for the following health care services:

Authorization for Chiropractic Examination/Treatment as is necessary and to perform the following manipulation/ therapy procedures considered therapeutically necessary on the basis of findings during the said course of examination/ treatment.

Authorization for Physical Therapy Examination/Treatment as is necessary and to perform the therapy procedures considered therapeutically necessary on the basis of findings during the said course of examination/ treatment.

Authorization for Acupuncture Examination/Treatment as is necessary and to perform the following therapy procedures considered therapeutically necessary on the basis of findings during the said course of examination/ treatment. I consent to the performance of acupuncture treatments and other procedures by a licensed Acupuncturist which may include but are not limited to acupuncture moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), and Gua Sha. I hereby acknowledge I have been informed of the purpose, benefits and risks of acupuncture and other procedures and potential side effects and complications. I will notify the Acupuncturist if I am or become pregnant. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. In accordance with 45:2C-5 the Standards governing practice of acupuncture. An acupuncturist shall advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition.

Authorization for Massage I understand that massage or bodywork may be contraindicated for certain medical conditions or symptoms. A referral from my physician or licensed health care provider may be necessary prior to service being provided. I further understand that massage or bodywork is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my appointment, I will inform the therapist so that the pressure or strokes may be adjusted accordingly. I understand that massage or bodywork should not be perceived by me as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical condition that I am aware of. I have been informed that massage and bodywork therapists are not qualified to perform skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session should be perceived as such. I understand that our massage therapists are trained professionals. At all times I will adhere to state and ethical compliant rules on draping and etiquette. Under professional guidelines our massage therapist employs full sheet draping to protect client modesty. The practitioner maintains the right to terminate a bodywork and massage session at will. I understand that any remarks or actions of a sexual or personal nature will result in immediate termination of the session and that no future appointments will be allowed. Because massage or bodywork should not be performed under certain medical conditions, I attest that I have stated all my known medical conditions and answered all questions honestly. I accept and voluntarily assume all risks of injury, damage, or harm which may arise during or as a result from my participation in massage or bodywork.

My initials and signature authorize consent for care and certifies that I have read and fully understand the Informed Consent for Care Document. I certify that no guarantee or assurance has been made me to the result that may be obtained.

Printed Patient Name: _____ Date: _____

Signature of patient or responsible party: _____ Relationship to patient: _____
(i.e. Patient is minor)

Fischer Health & Rehabilitation 413 King George Rd, Ste 205 • Basking Ridge, NJ 07920 • Phone • 908-903-1901 • Fax 908-903-1902

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Printed Patient Name _____ Date of Birth _____

I hereby authorize the following use or disclosure of my health information as described below:

The Type and Amount of information to be used or disclosed is as follows: (include dates where appropriate)
□Problem List □Medication List □List of Allergies □Most recent history and physical
□Most recent discharge summary □Consultation reports **X** Entire record
□Laboratory results from (date) _____ to (date) _____
□X-ray and image reports from (date) _____ to (date) _____
□Other_____

The individual or organization that is authorized to make the disclosure:
Name: Fischer Health and Rehabilitation
Address: 413 King George Rd., Suite 205 Basking Ridge, NJ 07920
Phone # 908-903-1901
Fax # 908-903-1902

This information may be disclosed to and used by the following organizations:
Names: Fischer Health and Rehabilitation, L & C Podiatry PC, Spark Medical
Address: 413 King George Rd., Suite 205 Basking Ridge, NJ 07920
Phone # 908-903-1901
Fax # 908-903-1902

Other individual or organization that is authorized to make the disclosure
(i.e. Attorney, Orthopedist, Primary Care MD, Radiologist)
Name: _____
Address: _____
Phone #_____
Fax #_____

This information may be disclosed to and used by the following other individual or organization:
(i.e. Attorney, Orthopedist, Primary Care MD, Radiologist)
Name: _____
Address: _____
Phone #_____
Fax #_____

Purpose of the Use / Disclosure:
X Referral to other Health Care Provider □ Referral for Radiological Studies
□ Reports to/ for referring Physician
□Other_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand I may inspect or coy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Signature of patient or responsible party: _____ Relationship to patient: _____
(i.e. Patient is minor)

ASSIGNMENT OF BENEFITS

Printed Patient Name: _____ DOB: _____

I hereby instruct and direct my current Health Insurance Company to pay by check made out and mailed to:

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

If my current policy prohibits direct payment to the health care provider, I hereby also instruct and direct (you) the patient or representative 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 the health care provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated: _____

Signature of Policy Holder or Claimant/ Responsible Party: _____
(i.e. Patient is minor)

Relationship to patient: _____