



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:** _____



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 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. During 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: _____

Relationship if not patient: _____



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PURPOSE: The information on this form will be used to provide all paper and electronic medical records as requested and to designate authorized individuals to receive verbal information.

ROUTINE USES: As noted in our HIPPA policy, as a patient at Fischer Health & Rehabilitation we may use or disclose personal and health related to your care with staff and providers for which the patient seeks services within this office. Your protected health information, including your clinical records, may be disclosed to another health care provider or organization such as imaging or medical equipment company 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.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION This form is also used to release your protected health information to a person or organization that you choose.

DISCLOSURE: Providing this information is voluntary. Failure to provide the information requested on this form may result in a lack of records release and ability collect payment from your insurance company.

Section A. Patient's Information (individual whose information will be released)

Full Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip code: _____

Section B. Description of the Information to be Released: (what type of information will be released)

All Records on File Other (Please Specify): _____

Section C. Designate individuals to receive Verbal Information You have the right to identify family, friends or others involved in your care to verbally receive medical or payment information about you, to help you manage your health care. This consent form does not authorize releasing copies of patient health records, which requires an Authorization for Use or Disclosure of Patient Health Information form. I consent verbally disclose the information.

Name	Phone No	Relationship

Section D. Authorization Expiration: This authorization will expire upon receipt of written request

Section E. Approval: (You or your Personal Representative MUST sign and date this form in order for it to be complete.)

I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission cannot be taken back. A copy of this is considered as valid as the original.

Requestor Signature: By signing below, I authorize the release of my protected health information as described above.

Signature _____ Date: _____

Relationship if not patient _____



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, of in-network insurance companies and a list of providers and/ or services that may work within our office or the patient may be referred to:

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
- Aetna PO Box 981106 El Paso, TX 79998-1106 (888) 632-3862

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 office:

- Chiropractors: Dr. David A. Fischer, DC and Dr. Steven M. Raymond, DC
- Physical Therapists: Erin Polos, PT and Renee A. Fischer, PT
- Acupuncturist: Rachel Specht
- Massage Therapist: Veronica Figueroa
- Personal Trainer: Linda Downey
- IV Nurse: Patricia Maldonado
- North American Medical Associates Lakshman Sundaram, MD (862) 206-7563
- L & C Podiatry PC Dr. Lenny Ramirez DPM, PACFAS 625 Main Ave #2, Passaic, NJ 07055 (973) 614-9800

Facilities Our Practice Is Currently Associated with and/ or refers to:

- 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

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. I may 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.

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:

- North American Medical Associates Lakshman Sundaram, MD (862) 206-7563

Please sign below to acknowledge that you understand all the above.

Printed Patient Name: _____ **Date:** _____

Signature: _____ **Relationship if not patient:** _____

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 Rehabilitation 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.** Patient may also need to be rescheduled if arrives late to appointment and is responsible for fee.

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 signature on this form acknowledges that I was offered a copy of this notice for additional information to determine indigency and that I do not need Indigency assistance.*

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. My 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.

Printed Patient Name: _____

Date: _____

Signature: _____

Relationship if not patient: _____

Informed Consent for Care

General. This form is to provide consent for care and explains the potential benefits and risks of treatment. I understand that there may be other forms of care practitioners for my condition which you may wish to discuss with your primary medical physician. I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment and 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. An acupuncturist shall advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition.

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](#)). 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

Patient's Consent. My signature authorizes 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. I hereby authorize Fischer Health & Rehabilitation for the following health care services as needed: Chiropractic, Physical Therapy, Acupuncture, and Massage. I will notify the providers if I am or become pregnant or have any changes to my health.

Printed Patient Name: _____

Date: _____

Signature: _____

Relationship if not patient: _____



ASSIGNMENT OF BENEFITS

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.

Printed Patient Name: _____ DOB: _____ Date: _____

Signature of Policy Holder or Claimant/ Responsible Party: _____

Relationship if not patient: _____