

10. What makes your problem worse?

- Nothing Walking Standing Sitting
 Moving around/exercise Lying down Inactivity

11. What prior treatments have you received for this present condition?

- Medical Surgical Physical therapy
 Acupuncture Other _____

Did the treatment help? Yes No

12. Are you currently taking any medications?

- Yes No

If yes, please describe. _____

13. Were you previously treated for an earlier occurrence of this same condition?

- Yes No

If yes, by whom?

- MD Chiropractor Physical therapist Other _____

What were the approximate dates, type of treatment and the results? _____

14. What is your physical activity at work?

- Mostly sitting Light manual labor
 Moderate manual labor Heavy manual labor

15. What general physical activity do you do?

- No regular exercise Light exercise Strenuous exercise

Describe _____

16. What is your present general stress level?

- No stress Minimal stress Moderate stress Greatly stressed

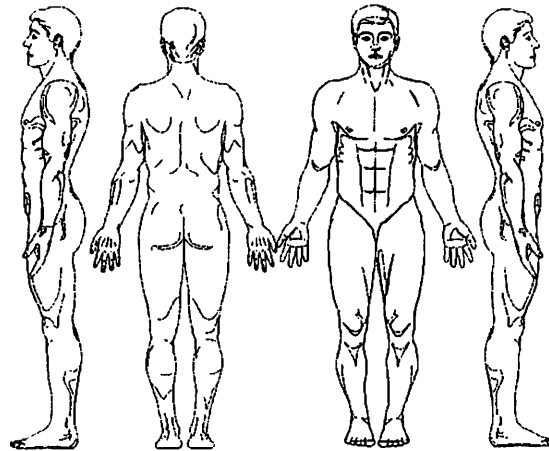
17. Is your problem affecting your ability to work or do other routine daily activities?

- No effect
 Need some assistance with daily activities
 Cannot function without assistance
 Have some limited physical restrictions, but can function
 Cannot work
 Totally disabled

Name _____

Date _____

Please mark an X on the figures below where you have pain, numbness or tingling.



Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

- | Past | Present |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> Arm/elbow pain |
| <input type="checkbox"/> | <input type="checkbox"/> Hand pain |
| <input type="checkbox"/> | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in upper leg or hip |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in ankle or foot |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling/stiffness of joints |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> General prolonged fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Condition of uterus/ovaries |

- | Past | Present |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> | <input type="checkbox"/> Respiratory condition |
| <input type="checkbox"/> | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney/bladder problem |
| <input type="checkbox"/> | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> | <input type="checkbox"/> Breast soreness/lump |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus conditions |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies/asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive weight loss/gain |
| <input type="checkbox"/> | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Prostate condition |

- | Past | Present |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> | <input type="checkbox"/> Caffeine (coffee, tea, soft drinks) |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Surgical Procedures. Please list: _____ |

- | Occasional | Moderate | Heavy |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature: _____ Date: _____

Jason Levy, DC, CCSP, CKTP, ART
Courtney Centrelli, DC, CKTP, ART
Michael Teytelbaum, DC, ART



C H I R O P R A C T I C

CONSENT TO ALLOW TREATMENT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including, but limited to, muscle strains and joint sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he/she feels at the time, based upon the facts then known, is in my best interest.

My doctor has responded to all my request for information about the proposed treatment. I have read, or have had read to me, the above consent. By signing below, I consent to treatment.

Patient Signature: _____ or

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Doctor Signature: _____ Date: _____

FINANCIAL AGREEMENT

Dear Patient:

We will attempt to provide you with information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment method to finance my care at the Advanced Performance and Rehabilitation Center:

_____ 1. CASH – Payment is due at the time of service.

_____ 2. MEDICARE – The Advanced Performance and Rehabilitation Center will complete all necessary Medicare forms on my behalf. I may be responsible for a co-payment after Medicare has paid the office.

_____ 3. PERSONAL INJURY – Although my insurance or lawsuit may eventually pay the Advanced Performance and Rehabilitation Center in full for service rendered, I will pay this office for any payments not made.

_____ 4. INSURANCE POLICY COVERAGE – I understand I am totally responsible for charges I may incur in this office. I will initially pay for my yearly deductible and the co-payment agreed upon at the time of each visit. It is my responsibility to know my insurance plan and to know if a referral is needed before the start of my care. If my insurance fails to pay its share, I will pay the balance in full.

NOTE: The Advanced Performance and Rehabilitation Center will refund any overpayments made to us upon completion of care.

THERE IS A 24 HOUR CANCELLATION POLICY. A \$60.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELED WITHIN 24 HOURS PRIOR TO THE SCHEDULED TIME.

THERE IS A \$50.00 ADDITIONAL CHARGE FOR ANY EMERGENCY VISITS OR OFFICE VISITS OUTSIDE OUR NORMAL OFFICE HOURS.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on my balance due, as well as all reasonable collection costs not to exceed 50%, as well as court costs, attorney fees and interest fees accrued with the collection of this account.

PATIENT'S SIGNATURE _____ Date: _____

WITNESS _____

Advanced Performance and Rehabilitation Center, LLC
532 Old Short Hills Road
Short Hills, NJ 07078
973-467-9011 • 973-467-9012 (Fax)

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. *Please review it carefully.*

Under new federal regulations, Advanced Performance and Rehabilitation Center, LLC along with all health care providers are required and obligated to maintain the privacy of your protected health information (PHI). This information may identify you & relates to your health, your conditions, and health care related services whether physical or mental.

This notice describes how we may use and disclose PHI information to other parties for the purpose of treatment, dispensing medications, and disclosing information to your health care provider or your physician via mail, phone or directly. We may use and disclose medical information so that services received at Advanced Performance and Rehabilitation Center, LLC may be billed to and payment may be collected from your insurance company, pharmacy benefit managers (PBM) or a third party.

We *may* use or disclose your PHI in accordance with the privacy rules without obtaining your consent or authorizations in the following instances. Contracted business associates rendering services for us in which PHI must be disclosed in order to perform their job (such as third party billing of your prescription drug benefits). Our business associates are required to protect your PHI in accordance to law. Discussions with individuals involved with your care or payment of your care if deemed appropriate by the health care professional. F.D.A. requirements to prevent serious health or safety threats to the public. Health oversight authorized by law including audits, investigations and inspections required for licensure and government monitoring of health care programs and civil rights issues. Workman's compensations claims. *As required by law.*

We are permitted to use and disclose PHI for the following purposes *In accordance to law:* Coroners, Medical & Funeral Directors to carry out their functions, Organ or Tissue procurement organizations, Judicial or administrative proceedings, law enforcement purposes, governmental authorities, and national security. Victims of abuse, neglect and domestic violence to protective service agencies. Military authorities.

You have the right in writing, to request restriction of certain uses & disclosures of PHI with regards to the nature of your treatment, payment, and health care operations to a family member, relative or representative. We are, however, not required by federal law to comply. If you request a copy of your PHI, you have the right to send it to a different location and by alternate means.

Further information or questions relating to your privacy rights may be addressed to *Dr. Jason Levy* (privacy officer). Please address any complaints regarding your privacy rights to our privacy officer or with the secretary of health & human services.

To be assured you received or read this notice *please sign and return* this notice at your earliest convenience.

Signature _____ print name _____

Recipient ___ Authorized Rep. ___ Family Member ___ Care Giver ___

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Short Hills, NJ 07078
973-467-9011 • 973-467-9012 (Fax)

Health Insurance Portability & Accountability Act (HIPAA)

***** PRIVACY NOTICE ACKNOWLEDGEMENT *****

Under new federal regulations, Advanced Performance and Rehabilitation Center, LLC along with all health care providers are required to maintain the privacy of your protected health information "PHI."

This notice describes how we may use and disclose your PHI.

To be assured you received and/or read this notice, please sign:

I have received and/or read Advanced Performance and Rehabilitation Center's Privacy Notice.

Signature _____ Date _____

Print Name _____

Recipient _____ Authorized Rep. _____ Family Member _____ Care Giver _____



Emergency Contact Form

Patient Name

Date

Please list the contact information of whom APRC should contact in case of an emergency

IMPORTANT: I am filling out this form for the first time (please mark):

Yes No I am updating from a previous form

FIRST EMERGENCY CONTACT:

SECOND EMERGENCY CONTACT:

(name: first, middle initial, last)

(name: first, middle initial, last)

(address 1: street, city, state, zip)

(address 1: street, city, state, zip)

(address 2: street, city, state, zip)

(address 2: street, city, state, zip)

(home phone)

(home phone)

(cell phone)

(cell phone)

(email)

(email)

Signature:

Date:

Home Phone:

Cell Phone:

Email:

In the event of an emergency you hereby acknowledge the listed person(s) to act on your behalf. The contact information that you provide APRC is strictly confidential and will not be used for any other sole purpose other than as set forth herein.