ADVANCED PERFORMANCE AND REHABILITATION CENTER
532 Old Short Hills Road
Short Hills, New Jersey 07078
Phone: 973-467-9011 / Fax: 973-467-9012

Today's Date: ___/___/_____

Patient Name: _____ Age: _____

Date of Birth: ___/___/____ Social Security #:_____-____-_____ Male ___ Female ___

Single _____ Married _____ Divorced _____ Widowed _____

Mailing Address: _____

City: _____State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mobile Phone: (_____) _____-_____ Mobile Provider: ☐ Verizon ☐ T-Mobile ☐ AT&T ☐ Sprint ☐ Other_____

May we send you text reminders for future appointments? ____ YES ____ NO

If yes, how far in advance of the appointment? _____ 1 hour ____4 hours ____24 hours

_____Employed _____ Full-Time Student ____Unemployed
_____Self –Employed _____ Part-Time Student ____Retired

Occupation: _____ Employer Name: _____

If the patient is a minor, name of parent/guardian: _____
Contact Number: _____

Do you have health insurance: _____YES _____ NO

If yes, Provider: _____ Policy Number: _____

Policy Holder: _____Self _____Other

If other, full name of policy holder: _____

Policy Holder Date of Birth: ___/___/____

Patient's relationship to policy holder: _____

Who may we thank for referring you to our office? _____

Name: _____ Age: _____ Today's Date: _____

INITIAL CHIROPRACTIC PATIENT INTAKE FORM & HEALTH ASSESMENT

1. What is your present complaint? _____

_____

2. How would you describe your pain?

- ☐ Sharp
- ☐ Dull
- ☐ Ache
- ☐ Soreness
- ☐ Stiffness
- ☐ Weakness
- ☐ Throbbing
- ☐ Spasm
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Shooting

3. How would you rate the intensity of your pain? (please circle)

0 1 2 3 4 5 6 7 8 9 10

(no pain) ——————————→ (terrible/unbearable pain)

4. How often is the pain present?

- ☐ Constant (80-100%)
- ☐ Occasional (25-50%)
- ☐ Frequent (50-80%)
- ☐ Intermittent (25% or less)

5. When did your problem begin? (give approximate date if possible) _____

6. Since your problem began is the pain:

- ☐ Getting worse
- ☐ Getting better
- ☐ Staying the same

7. How did your problem begin?

- ☐ An auto accident
- ☐ Gradual
- ☐ Work related accident
- ☐ Sudden
- ☐ Other type of accident
- ☐ No specific reason

8. Describe how the problem began. _____

_____

_____

9. What makes your problem better?

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

10. What makes your problem worse?

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

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

- ☐ Medical
- ☐ Acupuncture
- ☐ Surgical
- ☐ Other _____
- ☐ Physical therapy

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 _____

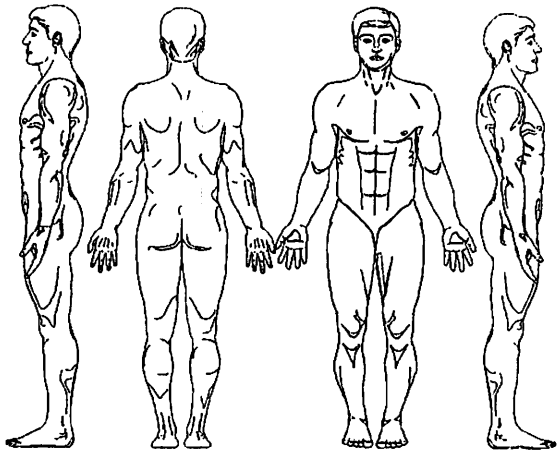
_____

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: _____ Age: _____ Today's 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		Past	Present	
☐	☐	Neck pain	☐	☐	High blood pressure
☐	☐	Shoulder pain	☐	☐	Heart condition
☐	☐	Arm/elbow pain	☐	☐	Respiratory condition
☐	☐	Hand pain	☐	☐	Digestive problems
☐	☐	Upper back pain	☐	☐	Kidney/bladder problem
☐	☐	Lower back pain	☐	☐	Menstrual problems
☐	☐	Pain in upper leg or hip	☐	☐	Breast soreness/lump
☐	☐	Pain in lower leg or knee	☐	☐	Sinus conditions
☐	☐	Pain in ankle or foot	☐	☐	Allergies/asthma
☐	☐	Jaw pain	☐	☐	Cancer
☐	☐	Swelling/stiffness of joints	☐	☐	Stroke
☐	☐	Headaches	☐	☐	Excessive weight loss/gain
☐	☐	Dizziness	☐	☐	Skin condition
☐	☐	Fainting spells	☐	☐	Arthritis
☐	☐	Convulsions	☐	☐	Diabetes
☐	☐	General prolonged fatigue	☐	☐	Prostate condition
☐	☐	Condition of uterus/ovaries			

Past	Present		Occasional	Moderate	Heavy
☐	☐	Tobacco use	☐	☐	☐
☐	☐	Alcohol use	☐	☐	☐
☐	☐	Caffeine (coffee, tea, soft drinks)	☐	☐	☐
☐	☐	Pregnancy			
☐	☐	Surgical Procedures. Please list: _____			

_____

_____

Patient's Signature: _____ **Date:** _____

a.p.r.c.
ADVANCED PERFORMANCE
& REHABILITATION CENTER

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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 not 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 risks 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. I have also had the opportunity to ask questions about its consent. By signing below, I consent to treatment.

Print Patient Name:_____

Print Parent/Guardian Name (if applicable): _____

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date: _____

Doctor Signature: _____ Date: _____

Emergency Contact Form

Patient Name: _____

Phone Number _____

IMPORTANT: I am filling out this form for the first time: ____YES ____NO, I am updating my information

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes, please explain.

_____

Emergency Contacts:

Primary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Secondary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Physician Contact:

Doctor's Name _____ Address _____

Phone Number _____ _____

Patient Authorization

I have voluntarily provided the above contact information and authorize APRC and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

_____ _____

Patient 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.

Verification of Benefits / Authorizations / Notice of Collection Action

APRC will try and verify my insurance benefits prior to my appointment. However, I understand I am solely responsible for knowing the benefits my insurance plan provides. Furthermore, it is my responsibility to ensure APRC has my current insurance coverage information and a copy of my valid identification card on file at all times in order to verify my coverage and ensure timely and accurate processing of all claims.

I understand all co-payments are due at the time services are rendered and I am responsible to pay any additional amounts due in full; including, but not limited to, annual deductibles, co-insurance, and any other charges denied for payment by my insurance company for any reason.

In the event my account balance is unpaid for longer than 30 days, I agree to pay a finance charge of 1.5% per month on all overdue charges. Additionally, should my account remain delinquent and/or be turned over to a collection agency, I am responsible to pay for any and all additional fees incurred (i.e. late fees, collection agency fees, attorney fees, court fees, etc.) not to exceed 50% of the balance due.

NOTE: The Advanced Performance and Rehabilitation Center will refund any overpayments made to us upon receipt of insurance payment.

THERE IS A 24 HOUR CANELLATION 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.

I AGREE THIS AUTHORIZATION SHALL REMAIN VALID UNLESS I RESIND IN WRITING.

PRINT PATIENT NAME: _____ Date: _____

GUARANTOR/PATIENT SIGNATURE: _____

Advanced Performance and Rehabilitation Center, LLC
532 Old Short Hills Road
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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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Health Insurance Portability & Accountability Act (HIPAA)

*** PRIVACY NOTICE ACKNOWLEDGEMENT ***

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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 ____