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 FOR MEDICARE PATIENTS

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 _____

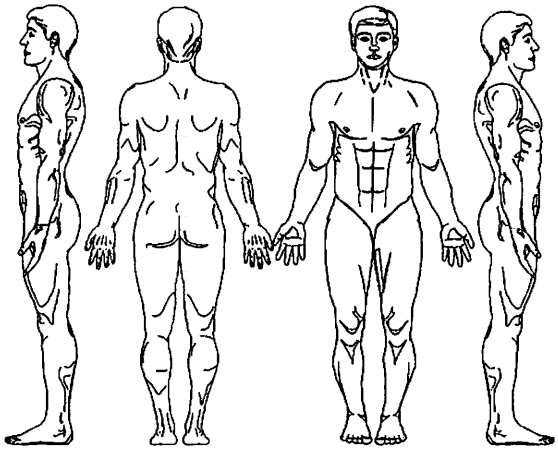
_____

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	
☐	☐	Neck pain
☐	☐	Shoulder pain
☐	☐	Arm/elbow pain
☐	☐	Hand pain
☐	☐	Upper back pain
☐	☐	Lower back pain
☐	☐	Pain in upper leg or hip
☐	☐	Pain in lower leg or knee
☐	☐	Pain in ankle or foot
☐	☐	Jaw pain
☐	☐	Swelling/stiffness of joints
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Fainting spells
☐	☐	Convulsions
☐	☐	General prolonged fatigue
☐	☐	Condition of uterus/ovaries

Past	Present	
☐	☐	High blood pressure
☐	☐	Heart condition
☐	☐	Respiratory condition
☐	☐	Digestive problems
☐	☐	Kidney/bladder problem
☐	☐	Menstrual problems
☐	☐	Breast soreness/lump
☐	☐	Sinus conditions
☐	☐	Allergies/asthma
☐	☐	Cancer
☐	☐	Stroke
☐	☐	Excessive weight loss/gain
☐	☐	Skin condition
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Prostate condition

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

_____

_____

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

A. Notifier: Advanced Performance and Rehabilitation Center

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. 97140 Active Release 2. 97014 Electrical Muscle Stim 3. 97110 Therapeutic Exercise 4. 97035 Ultrasound 5. 97012 Mechanical Traction 6. 97032 Pulsed Activation Therapy 7. 97010 Hot/Cold Pack	Medicare does not pay for this therapy for your condition.	1. $37.50 2. $35.00 3. $75.00 4. $35.00 5. $50.00 6. $50.00 7. $25.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

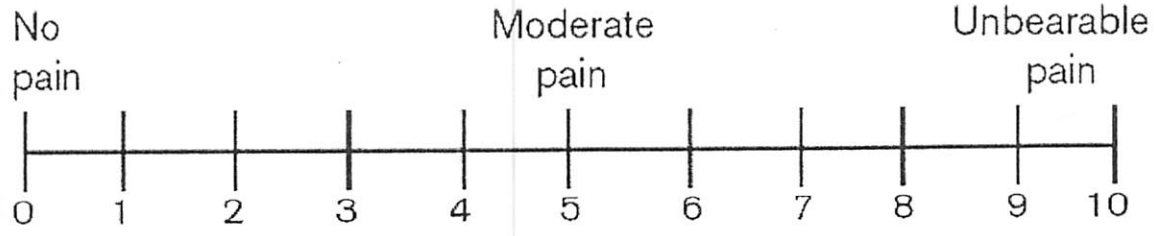
a.p.r.c.
ADVANCED PERFORMANCE
& REHABILITATION CENTER

Print Patient Name: _____

Date: _____

Please indicate your pain level prior to your visit today.

0-10 VAS Numeric Pain Distress Scale



Patient Signature:_____

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*

a.p.r.c.
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& 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: _____

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: _____