

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: _____

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: _____

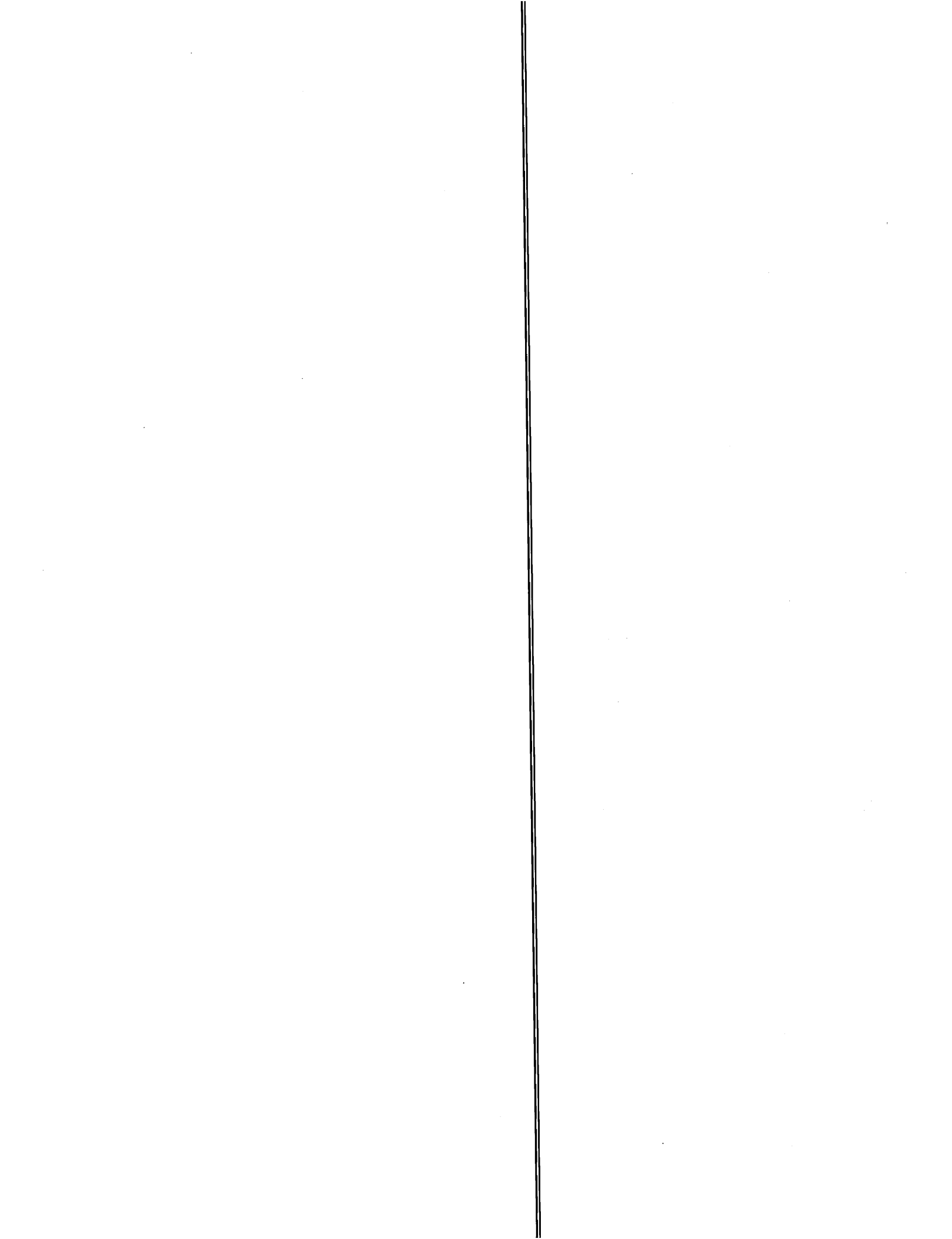
Policy holder: ___ Self ___ Other

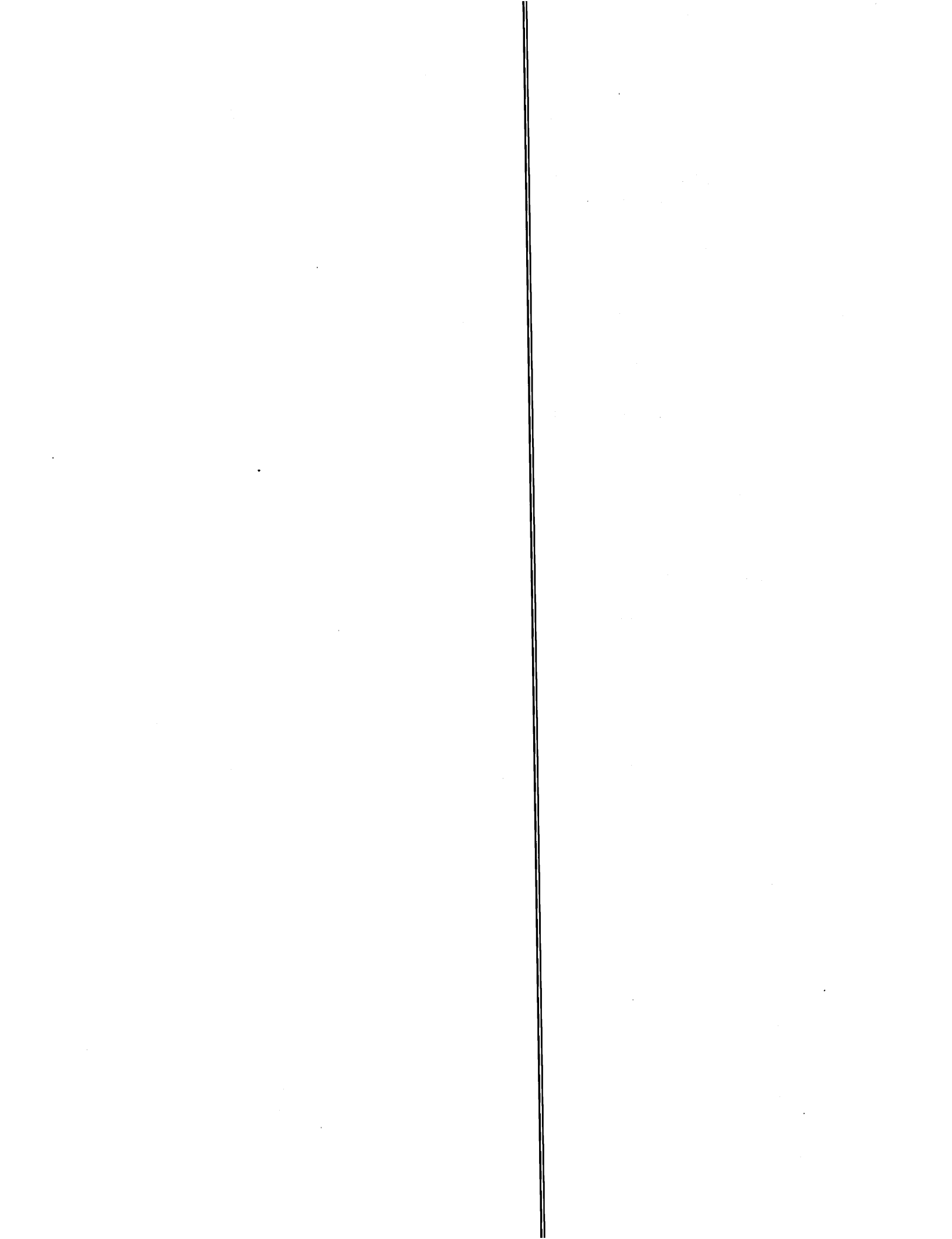
If other, full name of Policy Holder: _____

Policy holder Date of Birth: ___/___/___

Patient's relationship to Policy Holder: _____

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







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

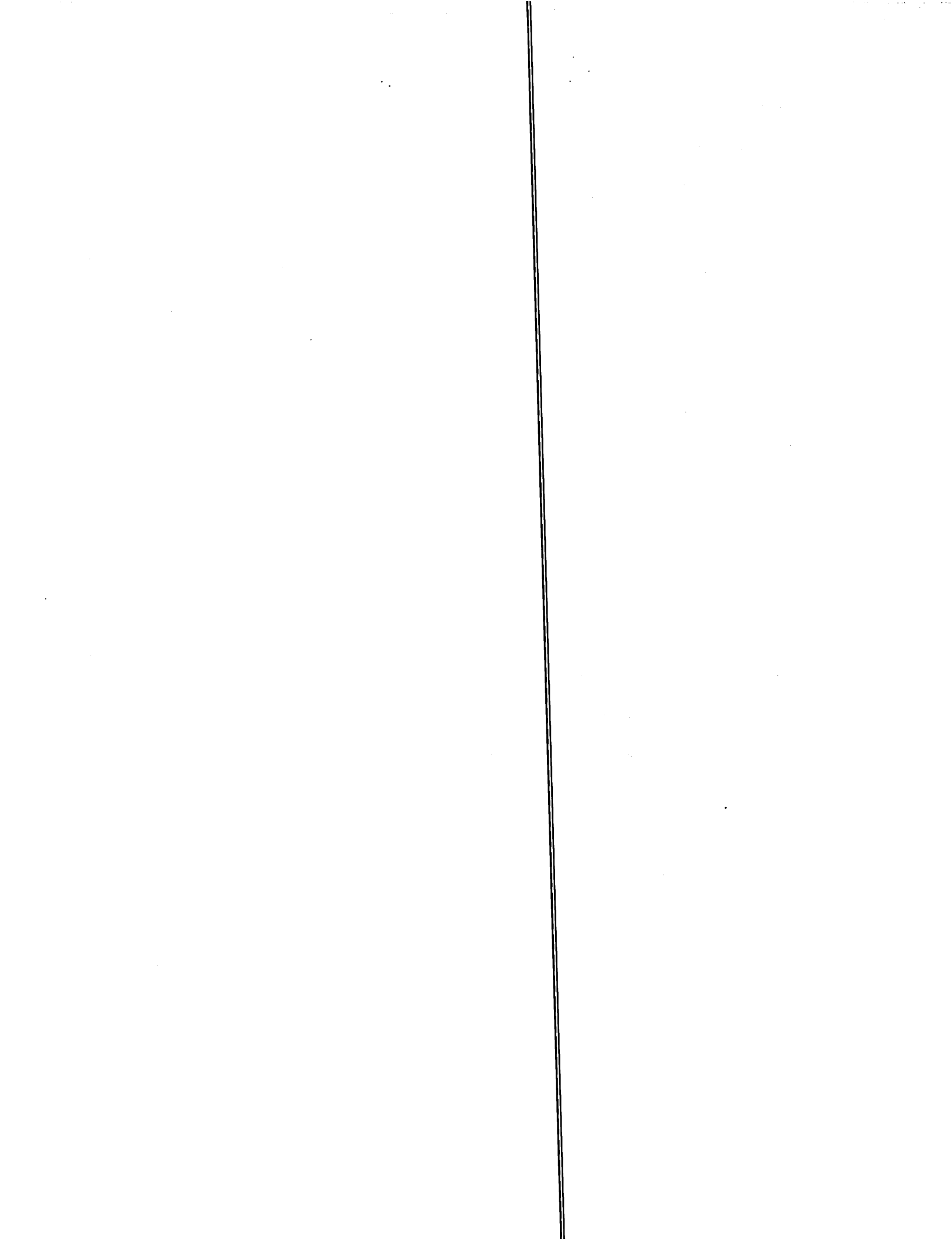
Describe _____

16. What is your present general stress level?

No stress Minimal stress Moderate stress Greatly stressed

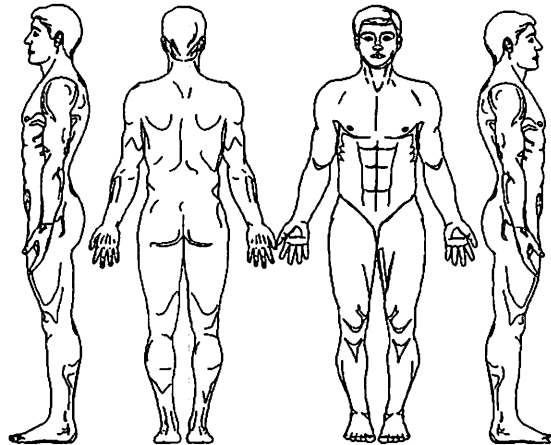
17. Is your problem affecting your ability to work or do other routine daily activities?

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.

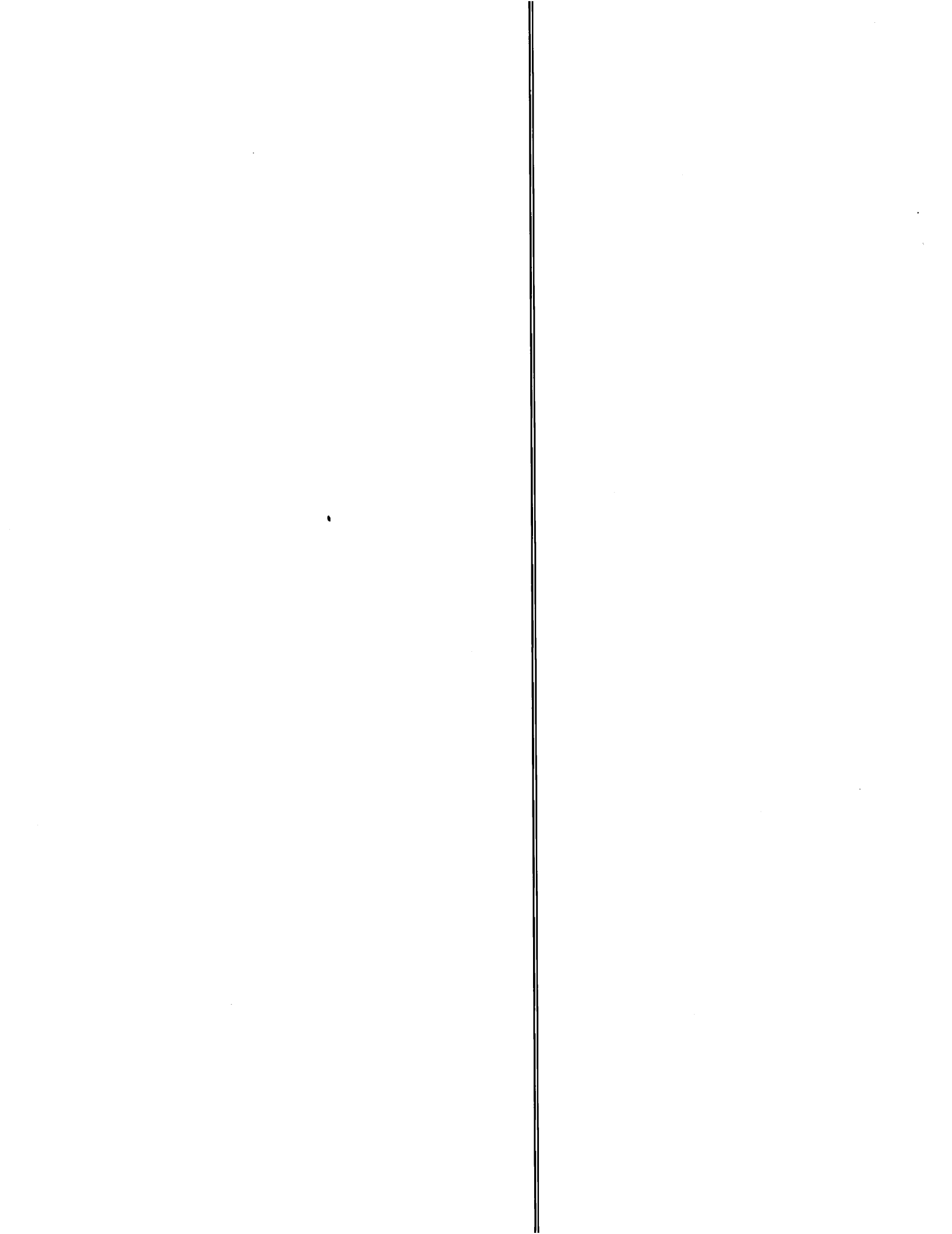
- | Past | Present |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> Arm/elbow pain |
| <input type="checkbox"/> | <input type="checkbox"/> 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: _____



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 | Medicare does not pay for this therapy for your condition. | 1. \$37.50 |
| 2. 97014 Electrical Muscle Stim | | 2. \$35.00 |
| 3. 97110 Therapeutic Exercise | | 3. \$75.00 |
| 4. 97035 Ultrasound | | 4. \$35.00 |
| 5. 97012 Mechanical Traction | | 5. \$50.00 |
| 6. 97032 Pulsed Activation Therapy | | 6. \$50.00 |
| 7. 97010 Hot/Cold Pack | | 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:

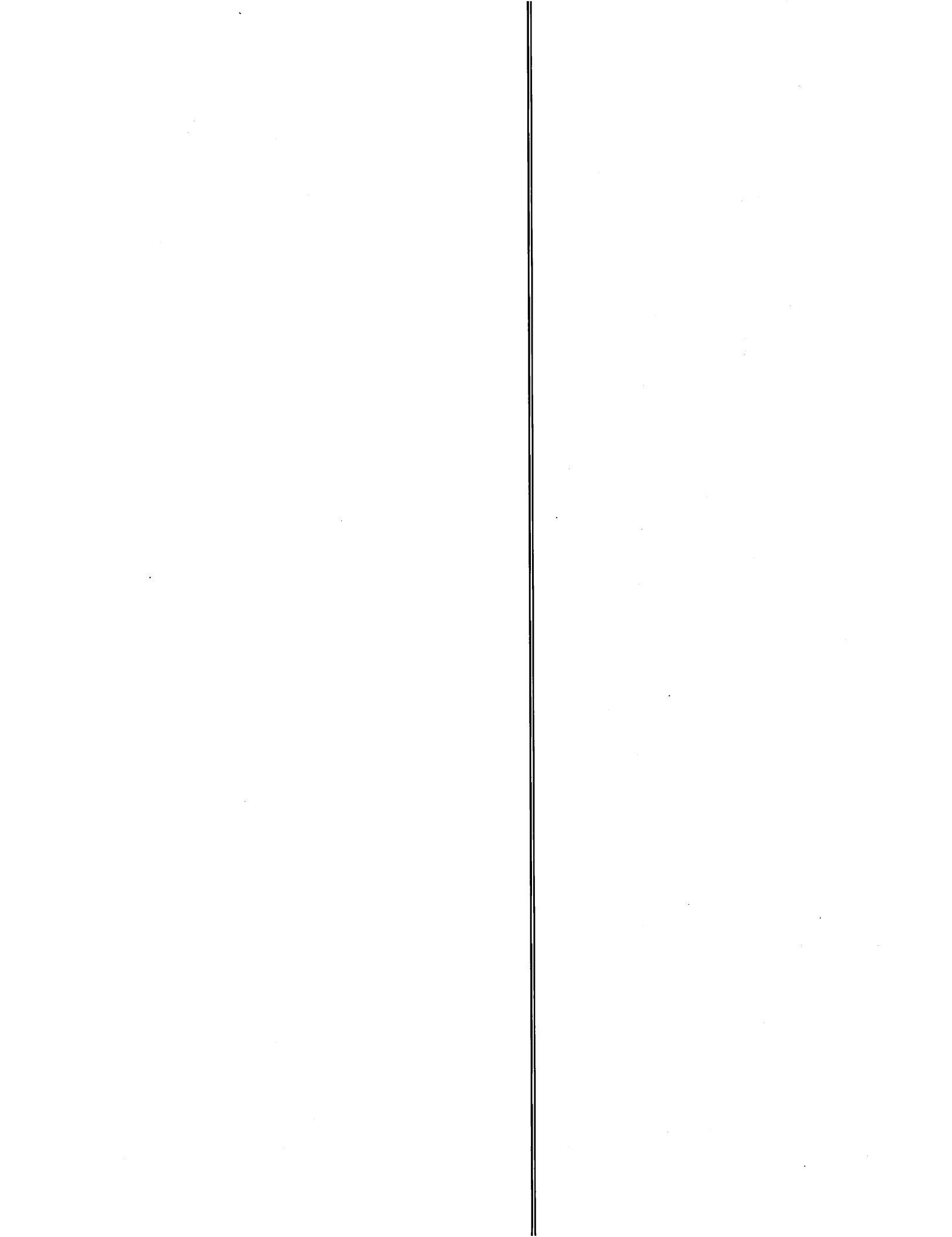
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



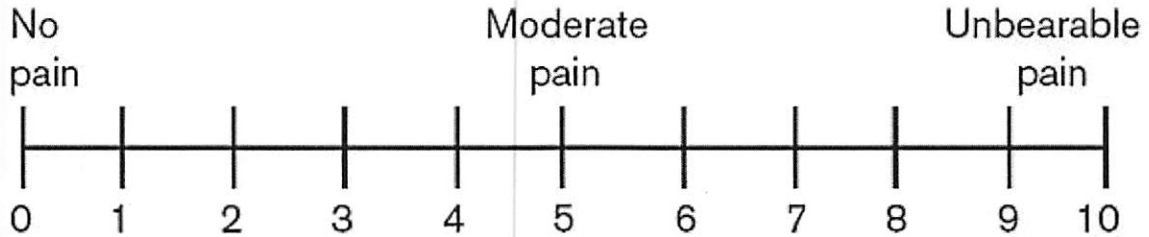


Print Patient Name: _____

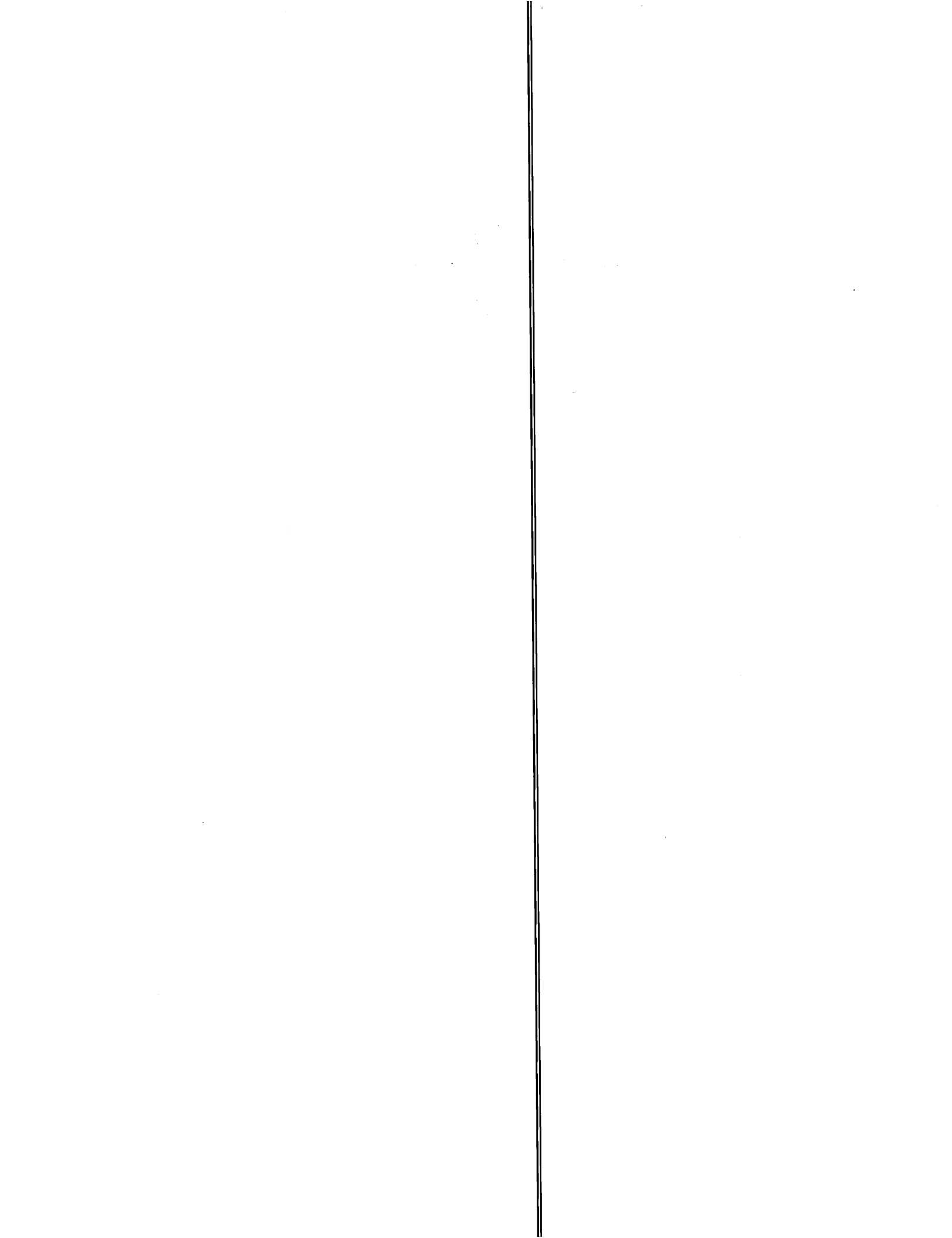
Date: _____

Please indicate your pain level prior to your visit today.

0 - 10 VAS Numeric Pain Distress Scale



Patient Signature: _____



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.

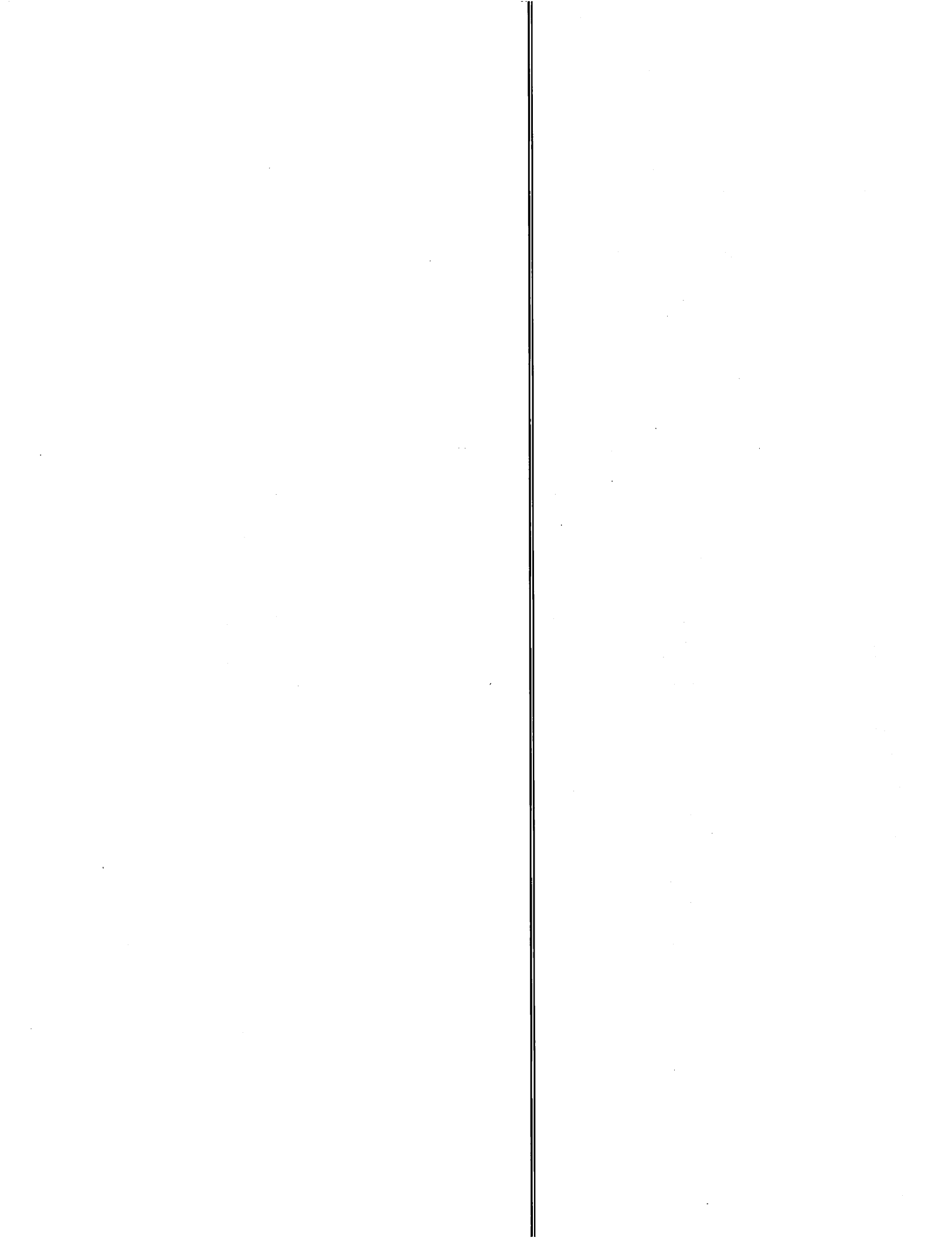
THERE IS A 24 HOUR CANCELLATION POLICY. A \$60.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELED WITHIN 24 HOURS PRIOR TO THE SCHEDULED TIME.

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

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
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.

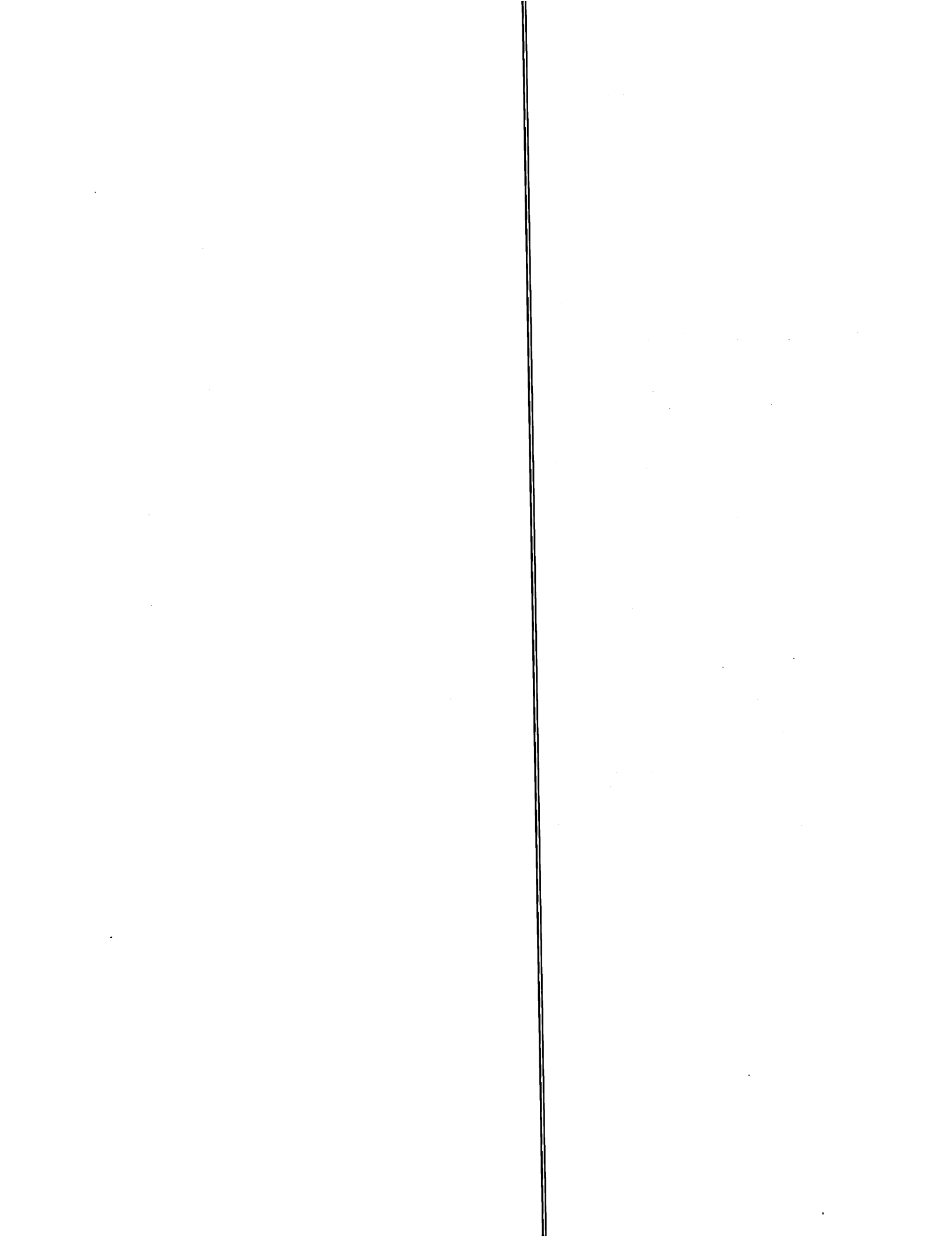
You have the right in writing, to request restriction of certain uses & disclosures of PHI with regards to the nature of your treatment, payment, and health care operations to a family member, relative or representative. We are, however, not required by federal law to comply. If you request a copy of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

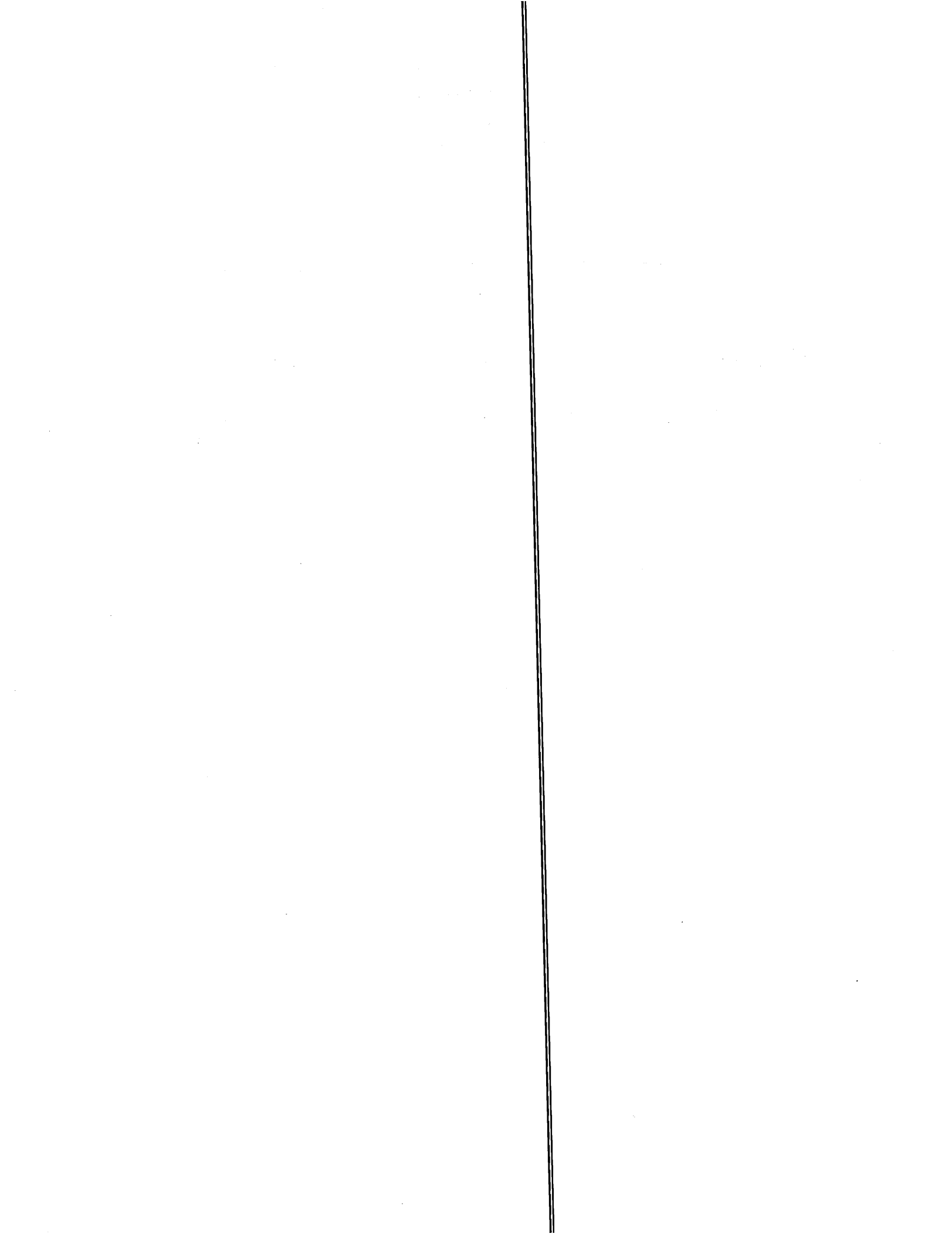
To be assured you received and/or read this notice, please sign:

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: _____ |
| 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.

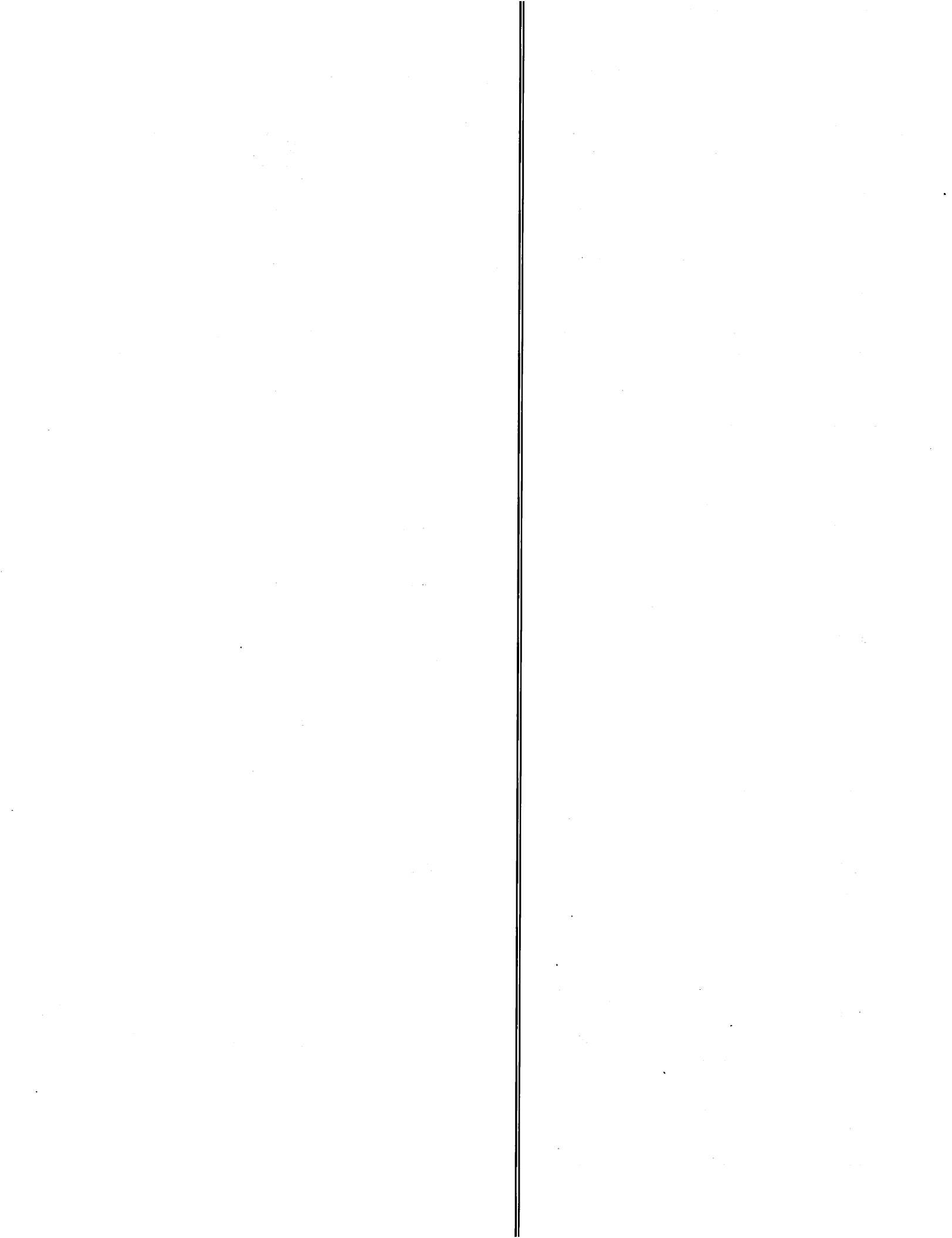
Emergency Contacts:

| | |
|--|------------------------------|
| 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. | |
| _____ <i>Employee signature</i> | _____ <i>Date</i> |



Directions to APRC

532 Old Short Hills Road, Short Hills, NJ 07078
973-467-9011

From Millburn: Take Old Short Hills Road towards St. Barnabas Hospital. Cross over South Orange Avenue and continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right), just before the brick garden apartments. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From JFK Parkway: Take JFK Parkway away from the mall, towards Livingston. Make a right at the first traffic light onto South Orange Avenue. Continue on South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From the Livingston Mall on South Orange Avenue: Take South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From South Orange: Take South Orange Avenue to Old Short Hills Road. Make a right at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From West Orange: Take Northfield Avenue to the traffic light at Old Short Hills Road. You will see the Livingston Diner on the far left corner, the Northfield Cleaners on the closest corner on the left, and Master Pizza on your right. Make a left onto Old Short Hills Road. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From Livingston (Northfield Avenue): Make a right onto Old Short Hills Road. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From 280 East: Take 280 East to exit 6A (Laurel Avenue). Follow the blue and blue "H" signs for St. Barnabas Hospital. Bare left at the fork in the road onto Shrewsberry Drive. Continue straight on Shrewsberry Drive. Cross over Mt. Pleasant Avenue (Route 10). Shrewsberry Drive will change its name to East Cedar Lane. Just continue straight. Cross over Northfield Avenue and continue to go straight. The road merges into Old Short Hills Road. Continue on Old Short Hills Road, through approximately 2-3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

