SADDLE BROOK
Chiropractic & Physical Therapy
Atlantic Wellness Chiropractic P.C. & Scott Bensky Chiropractic, LLC

PATIENT CASE HISTORY

CONTACT INFORMATION

Name:____**DOB:** ________/______/____________

Address:____ **City:**_________________________

State:________ **Zip:**______________ **Email:**____

Occupation:________________________________**SS#:**____________________ **Age:**_____________

Phone Number:_____________________________ **Cell Phone:**___________________________________

# of Children:____________________ **Marital Status (circle one):** **Married / Single / Widowed / Divorced**

Referring Doctor:____________________________ **Phone Number:**_____________________________

Emergency Contact:

Name: ____ **Relationship:**_________________________

Phone Number: ___________________________________

HEALTH INFORMATION

Have you received previous Chiropractic Care? ☐ **Yes** ☐ **No** **Physical therapy Care?** ☐ **Yes** ☐ **No**

What is your major complaint?____

____

Onset of complaint/condition:____

How long have you had this condition? __________________ **Has this happened in the past?** ☐ **Yes** ☐ **No**

What activities aggravate your condition?____

Is your condition getting progressively worse? (circle one) **Yes** **No** **Constant** **On and Off**

Is this condition interfering with your work? ☐ **Yes** ☐ **No** **Is it interfering with your sleep?** ☐ **Yes** ☐ **No**

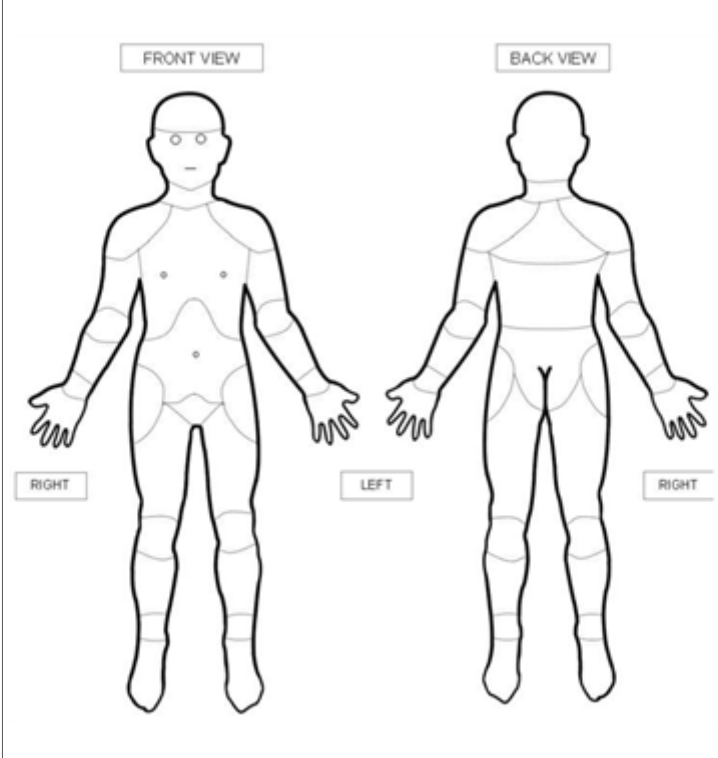
Is this condition interfering with your daily activity? ☐ **Yes** ☐ **No**

Do other family members have similar problems? ☐ **Yes** ☐ **No** **Please List:**____________________

Other doctors who have treated this condition:____

Date of last physical exam: ______/_____/______

Please mark pain in areas below:



Have you ever suffered from the following conditions? Check if applicable.

- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Anxiety
- ☐ Sinus Trouble
- ☐ Neck Pain
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Visual Impaired
- ☐ Hearing Impaired
- ☐ Latex Allergy
- ☐ Digestive Disorders
- ☐ Pacemaker
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Dizziness
- ☐ Backaches
- ☐ Allergies:______________
- ☐ Other:________________

Please list any surgical operations and the year they were performed:____________________________________

____

Please circle the drug you are currently taking: Nerve Pills • Pain Killers • Muscle Relaxers • Pep Pills

Tranquilizers • Insulin • Birth Control Pills • Other:____

Age of Mattress: _____________ **Is it comfortable?** ☐ **Yes** ☐ **No**

Do you wear any of the following? (circle applicable): Heel lifts • Inner soles • Arch Support

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐ **Yes** ☐ **No**

Have you ever been in an auto accident? If yes, please describe:____

____

Have you had any other personal injury, job related injury, or accident? If yes, please describe:______________

____

Primary Insurance Company:

Insurance Company Name:______________________________ **Insurance Phone #:**_______________________

Patient ID:______________________________ **Group #:**__________________ **Policy/Plan #:**______________

Policy Holder:____

Are you covered by Medicare? ☐ **Yes** ☐ **No**

Insurance Policy #:_____________________________________

Payment Authorization: **(initials required for all 3 statements)**

__________ *initals* **Assignment of insurance Benefits** I authorize that the payment of my insurance benefits be made directly to this office for all services delivered; if I am paid directly I will promptly pay this office all monies paid to me

__________ *initals* **Guarantee of Payment** I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductible are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

__________ *initals* **Certification of Information** I certify that the information I have provided this office for payment including by not limited to, related accidents, illnesses or other insurers is accurate and truthful.

I attest, to the best of my knowledge, the above information is accurate and true.

____
Print Name

____
Signature

_______/______/____________
Date

NOTICE OF PATIENT INFORMATION PRACTICES

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

Saddle Brook Chiropractic and Physical Therapy's Legal Duty It is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow information practices that are described herein.

Uses and Disclosures of Health Information Saddle Brook Chiropractic and Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Saddle Brook Chiropractic and Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Saddle Brook Chiropractic and Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Saddle Brook Chiropractic and Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights You have the right to review and obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Saddle Brook Chiropractic and Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints If you are concerned that Saddle Brook Chiropractic and Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

Saddle Brook Chiropractic and Physical Therapy, 380 N. Midland Ave, Saddle Brook, NJ, 07633 (201) 880 - 7077

SADDLE BROOK
Chiropractic & Physical Therapy
Atlantic Wellness Chiropractic P.C. & Scott Bensky Chiropractic, LLC

LATE CANCELLATION POLICY

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. Please see our missed/cancelled appointment guidelines below.

If you are unable to keep your schedule appointment, we require a 24 hour notice (1 full business day) so that we may accommodate the physical therapy/CORE CAMP needs of another patient. If an appointment isn't cancelled or reschedules within 24 hours of the reserved appointment time, Saddle Brook Chiropractic and Physical Therapy will change the patient a cancellation fee.

Physical Therapy/CORE CAMP visits: Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In the event you are late cancel/failed appointment, the patient is charged $25 fee.

Thank you!

____
Print Name

____
Signature

______/_____/___________
Date

OFFICE POLICY REGARDING BLUE CROSS BLUE SHIELD CHECKS

Dear Patients,

This letter is to inform you that you will be directly receiving checks from your insurance carrier (Blue Cross Blue Shield) for treatments that you have received in our office. It is your responsibility that you forward these checks and any other correspondence that is included with your checks into the office. In the event that you withhold such checks, you are ultimately ***responsible*** for the amount on these checks, as well as the balance of your account. If you do not comply, you are subject to legal ramification. By signing this letter you agree and acknowledge the terms stated above.

____

Print Name

____

Signature

______/______/____________

Date

New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act ("Act")

Disclosure and Acknowledgement Form

Saddle Brook Chiropractic and Physical Therapy / Atlantic Wellness Chiropractic P.C, hereby notifies you of the follow:

I. Provider is in-network with respect to the following health benefits plans: **None**

II. Provider is out-of-network with respect to all health benefits plans **not** listed above

III. You have the right to request for the Provider the amount or estimated amount that Provider will bill you for the services available upon your request.

IV. You have the right to request that Provider provide you, in writing, with a list of services and CPT Codes associated with those services, absent of any unforeseen medical circumstance which may arise during the course of your treatment, as well as the amount or estimated amount that Provider will bill you for such services.

V. You are aware that, with respect to Provider, who is out-of-network with your benefit plan:

- **a.** You will have financially responsibility applicable to the health care services provided by the Provider in excess of your co-payment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plans.
- **b.** You should contact your carrier for further additional information on those costs.

VI. The receipt an acknowledgement of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

VII. If between the time you were notified of the Provider's network status and the time of your procedure, the network status of Provider's changed, then Provider shall promptly notify you of the same.

New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act ("Act")

Disclosure and Acknowledgement Form

Scott Bensky Chiropractic, LLC hereby notifies you of the follow:

I. Provider is in-network with respect to the following health benefits plans: Medicare, UHC, UMR and Oxford Health Plans

II. Provider is out-of-network with respect to all health benefits plans **not** listed above.

III. You have the right to request for the Provider the amount or estimated amount that Provider will bill you for the services available upon your request.

IV. You have the right to request that Provider provide you, in writing, with a list of services and CPT Codes associated with those services, absent of any unforeseen medical circumstance which may arise during the course of your treatment, as well as the amount or estimated amount that Provider will bill you for such services.

V. You are aware that, with respect to Provider, who is out-of-network with your benefit plan:

- **a.** You will have financially responsibility applicable to the health care services provided by the Provider in excess of your co-payment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plans.
- **b.** You should contact your carrier for further additional information on those costs.

VI. The receipt an acknowledgement of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

VII. If between the time you were notified of the Provider's network status and the time of your procedure, the network status of Provider's changed, then Provider shall promptly notify you of the same.

SADDLE BROOK
Chiropractic & Physical Therapy
Atlantic Wellness Chiropractic P.C. & Scott Bensky Chiropractic, LLC

DISCLOSURE AGREEMENT

I hereby acknowledge that, prior to the scheduling of my appointment, I have received the foregoing disclosures. I have read the foregoing, Understanding its contents, and have had the opportunity to ask questions regarding the same, as well as consult with my health benefits plan in connection with the disclosures provides in this document. Being fully aware of the out-of-network status of the provider, I hereby knowingly, voluntarily, and specifically select provider for the performance of services/my procedure and related ancillary services. 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. I am not being coerced to sign the disclosure, and do so upon my own free will.

____
Print Name

____
Signature

_______/______/____________
Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1														NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

POS Reorder # D4170621