Body Wellness & Rehabilitation, LLC

2909 Washington Road – Suite 175
Parlin, NJ 08859

PH #: 732-727-5502
FAX #: 732-727-5503

Patient Information Date___________

Personal History

Name____________________ Date of Birth__________ Age_______

Social Security # ____ - ____ - _____ Address __________________________

City ________________ State ______ Zip Code _________

Home Ph # _____ - _____ - ______ Cell Ph # _____ - _____ - ______

Are you: Married□ Single□ Divorced□ Separated□ Widowed□ # of children____

Emergency Contact: Name __________________ Ph # ____ - ____ - _____

Insurance Information

Primary Insurance: □Self Payment (Cash Plan) □Auto Insurance : _____________
□Personal Insurance : ______________

Secondary Insurance: □Yes __________________ □ No

Current Health Conditions

1) Have you had any spinal surgery? □Yes □ No

2) Have you had an auto accident or personal injury in the past 3 months? □Yes □ No

3) Do you have a pacemaker? □Yes□ No

Occupation

Employer___________________ Location ___________________

Position ___________________Type of work __________________

How did you hear about our office? ______________________________

Do you know anyone who would benefit from our care? ___________________________

WHY ARE YOU HERE?

Neck Pain? ☐Yes☐ No (If yes, answer the questions in this box. If not, skip to the next section.)

How long have you had the pain?_______ Have you had similar pain before?☐Yes☐No

Does the pain travel to: ☐R or ☐L Shoulder ☐R or L Arms ☐R or L Hands

Numbness of the arms/hands? ☐Yes☐ No

Loss of skin sensation in the arms/hands? ☐Yes☐ No

Muscle weakness of the arms/hands? ☐Yes☐ No

Pain Level (1-10) _____________ Does the pain increase intermittently? ☐Yes☐ No

What aggravates your current neck pain? ____________________

What relives your current neck pain? ____________________

Have you seen other doctors for this condition? ☐Yes☐ No

Result?(if any) ____________________

Headaches? ☐Yes☐ No (If yes, answer the questions in this box. If not, skip to the next box.)

How often?____________________

Location: ☐Front ☐Back ☐Left side ☐Right side

What aggravates your headaches? ____________________

What relives your headaches? ____________________

Upper or Mid Back Pain? ☐Yes☐ No (If yes, answer the questions in this box. If not, skip to the next section.)

How long have you had the pain?_______ Have you had similar pain before?☐Yes☐No

Does the pain travel: ☐Up or ☐Down the spine ☐Around to the front of your body

Numbness of the upper/middle back? ☐Yes☐ No

Loss of skin sensation in the upper/middle back? ☐Yes☐ No

Muscle weakness of the upper/middle back? ☐Yes☐ No

Pain Level (1-10) _____________ Does the pain increase intermittently? ☐Yes☐ No

What aggravates your current neck pain? ____________________

What relives your current neck pain? ____________________

Have you seen other doctors for this condition? ☐Yes☐ No

Result?(if any) ____________________

Lower Back Pain? ☐Yes☐ No (If yes, answer the questions in this box. If not, skip to the next section.)

How long have you had the pain?_______ Have you had similar pain before?☐Yes☐No

Does the pain travel to: ☐R or ☐L Glut muscles ☐R or L Knees ☐R or L Feet

Numbness of the legs/feet? ☐Yes☐ No

Loss of skin sensation in the legs/feet? ☐Yes☐ No

Muscle weakness of the legs/feet? ☐Yes☐ No

Pain Level (1-10) ______________ Does the pain increase intermittently? ☐Yes☐ No

What aggravates your current neck pain? ____

What relives your current neck pain? ____

Have you seen other doctors for this condition? ☐Yes☐ No

Result?(if any) ____

Please list any other medical information that may be helpful in your rehabilitation:

____

____

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Date___________

I, ___________________________ authorize the release of my complete medical records to Dr. John F. Marullo, DC and to requesting insurance companies, physicians, and employers as needed. I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster or attorney involved in this case.

Patient name ________________________ Patient Signature _________________

Witness initials _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

I, ____________________________ hereby authorize and direct ____________________

Insurance carrier to pay by check made out and mailed directly to:

Body Wellness & Rehabiliation, LLC

2909 Washington Road, Suite 175

Parlin, NJ 08859

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made out to me as follows:

C/O Body Wellness & Rehabiliation, LLC

2909 Washington Road, Suite 175

Parlin, NJ 08859

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment of the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient name ___________________________ Patient Signature ______________________

Policy Number __________________________ Date _________________

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INSURANCE PAYMENT AGREEMENT

I, ___________________________, have been made aware that Body Wellness & Rehabilitation, LLC is a non participating provider with ________________ Insurance carrier. I understand that payments for services rendered by this facility could be sent to me as the member. In the event of direct payment to the patient, I WILL IMMEDIATELY ENDORSE AND FORWARD THE ORIGINAL INSURANCE CHECK ALONG WITH THE EXPLANATION OF BENEFITS to:

Body Wellness & Rehabiliation, LLC
2909 Washington Road, Suite 175
Parlin, NJ 08859

I understand that if I don't comply with the above, I will be held personally responsible for the full amount billed to the insurance company, 24% APR interest for the outstanding balance and all legal/collection fees that will be associated to the debt incurred.

I acknowledge that I understand and agree with the above legal binding agreement.

Patient name ___________________________ Patient Signature ______________________

Date _________________

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Date___________

I, _________________________ have received a copy of the NOTICE OF PRIVACY PRACTICES that describes that my medical information may be used and disclosed and how you may gain access to this information.

Patient name ______________________ Patient Signature ________________

Your Individual Rights

You have the following rights regarding the health information we maintain about you. You should contact our Privacy Officer as noted below to answer any question about your rights or to request the required forms.

1. **Request Restrictions.** You may request that we place additional restrictions on the use or disclosure of your health information. Your request must be made in writing and our agreement may only be given in writing. We are not required by law to agree to your request, but if we do agree to the additional restriction, we will abided by them except in the event of an emergency.
2. **Confidential Communications.** You may request that we communicate with you confidentially through alternative means or at alternative locations. For example, you may request that we call you only at work or at a location other than your home. Your request must be made in writing and we will accommodate all reasonable requests.
3. **Inspection and Copies.** Subject to certain limited exceptions, you have the right to inspect and to obtain a copy of your health information that we maintain in our medical and billing records. During any appointment for diagnostic or treatment services, you will be permitted to review the medical records utilized by your treating physician. At any other time, for any other health information that we maintain in our records or for a copy of your Health Information, you must submit a request in advance and in writing. We may charge you a reasonable fee for the copy, for postage and, if requested, for preparation of a summary.
4. **Amend Information.** You may request that we amend your Health Information that we maintain in our medical and billing records. You must submit your request in writing on a form we provide and you must explain why the Health Information should be amended. We may deny your request if we did not create the Health Information in question or if we believe that the Health Information is accurate and complete or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement and it can be added to the information you sought to change. If we accept your request, we will make reasonable efforts to inform others that you or we identify as having previously received the Health Information in question and will include the changes in any future disclosures of the information.
5. **Accounting.** You have the right to request an accounting of certain non-routine disclosures of your Health Information, including the date of the disclosure, the identity of the person or entity that received the information, a description of the information disclosed and the purpose of the disclosure. The payment and health care operations, for disclosures made pursuant to your authorization or for disclosers made before April 14, 2003 or made more than six (6) years before your request. Your request for an accounting must be submitted in writing.
6. **This Notice.** You have the right to receive a paper copy of this Notice upon request.

Complaints

You may submit a complaint to our Privacy Officer and to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. We support your right to protect the privacy of your Health Information and will not retaliate against you for filing a complaint. You must submit your complaint to your Privacy Officer in writing. You may hand deliver the complaint to our office in an envelope addressed to the attention of the Privacy Officer or you may mail the complaint to our Privacy Officer at the address noted below. Complaints to the Secretary should be mailed to: Region II Office of Civil Rights, United States Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278.

Contact Person

If you have any questions about this notice or your privacy rights, you may contact our Privacy Officer at the following address or phone number:

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