PHYSICAL THERAPY
CHIROPRACTIC
ACUPUNCTURE
MASSAGE THERAPY

New Patient Paperwork

Name _____

Date _____

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Sex: Male Female Marital Status: Married Single Divorced DOB:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Home #:_____ Work #:_____ Cell #: _____

Email:_____ Cell Provider:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Spouse's Name:_____ Parent's Name (If patient is aminor):_____

Employed: Full Part Unemployed Student:_____ School:_____

Employer Name:_____ Employer Address:_____

Occupation:_____ How did you hear about our office? Name: _____

Insurance Information

Primary Ins:_____ Phone #:_____ ID#:_____

Claim Address:_____ Group#_____

_____

City: _____ State: _____ Zip Code:_____

Subscriber Name_____ Subscriber DOB:_____ Secondary ID#:_____

Secondary Ins_____ Secondary Phone #:_____ Secondary GRP#:_____

Secondary Address: _____

City: _____ State: _____ Zip Code:_____

Subscriber Name_____ Subscriber DOB:_____

Complaint Information

How did injury occur? Auto Accident Work School Sports Other

Date of injury_____

Describe discomfort_____

Frequency of pain: Always Hourly Daily Occasionally

Does pain interfere with activities_____Pain interfere with sleep? _____

Are you able to work? Yes No Explain _____

Have you received treatment? Yes No Explain _____

Xray's? Yes No Date _____

MRI? Yes No Date _____

History Information

Last physical exam_____ Primary Care Physician_____ Phone#_____

Height_____Weight_____

Previous Chiropractic: Yes No Explain: _____

Previous PT: Yes No Explain: _____

Previous Acupuncture: Yes No Explain: _____

Previous Massage: Yes No Explain: _____

Pregnant: Yes No Planning: Yes No

Medications: _____

Supplements: _____

Broken Bones: Yes No Explain: _

Sprains: Yes No Explain: _

Hospitalized: Yes No Explain: _

Surgery: Yes No Explain: _

New Patient Paperwork

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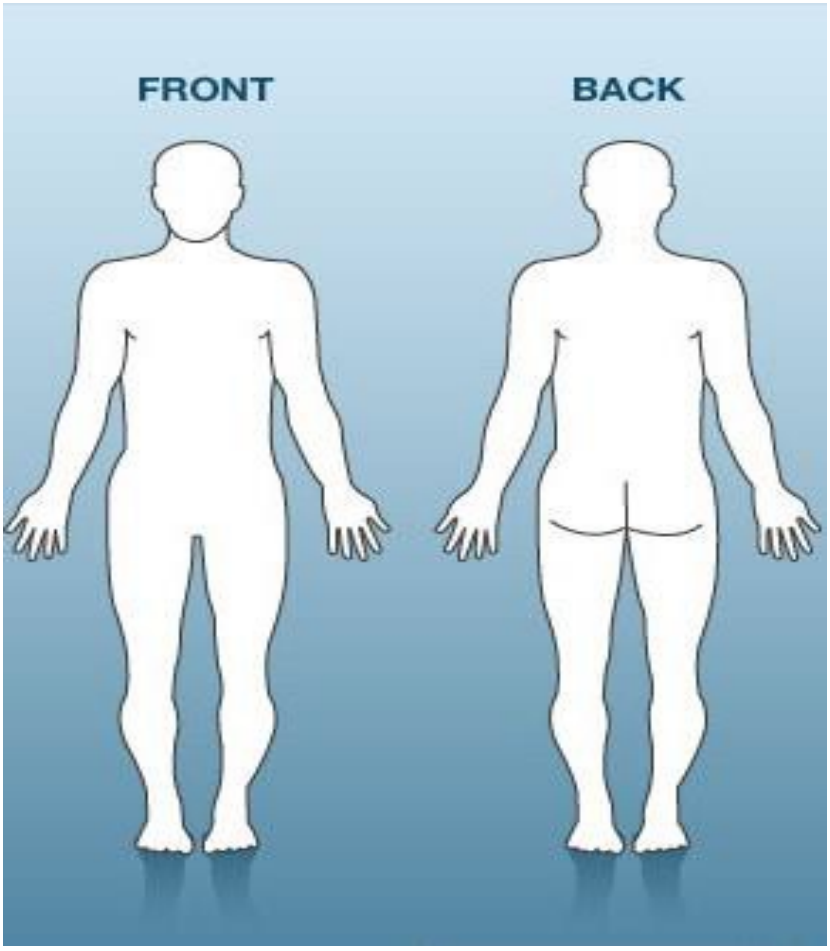
Please Mark Your Symptoms



Notes:

Doctor's Notes:

18 Wyckoff Avenue Suite 201 Waldwick, NJ 07463
Phone: 201-447-5757 Fax: 201-447-5750
Totalhealth@drstevejones.com

New Patient Paperwork

Name _____

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Health Checklist (Please check all that apply)

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis/Rheumatoid	Asthma
Back Pain	Breast Lump	Bronchitis
Bruise Easily	Cancer	Chest Pain
Cold Extremities	Constipation	Cramps
Depression	Diabetes	Digestion Problems
Dizziness	Excessive Menstruation	Eye Pain/Difficulties
Fatigue	Frequent Urination	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heartbeat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Loss of Memory	Loss of Balance
Loss of Smell	Loss of Taste	Nosebleeds
Pacemaker/Defibrillator	Polio	Poor Posture
Prostate	Sciatica	Shortness of Breath
High Blood Pressure	Sinus Infection	Insomnia
Spinal Curvatures	Stroke	Swelling of Ankles
Swollen Joints	Thyroid Condition	Tuberculosis
Ulcers	Varicose Veins	Heart Disease
Seizures	STDs	HIV
Hepatitis	Osteoporosis/Osteopenia	Multiple Sclerosis
Blood Clots	Latex Sensitivity	Parkinson's Disease
Pelvic Organ Prolapse	Urinary Incontinence	Pelvic Pain

Social Information

Alcohol:	Daily	Weekly	Occasionally	Never
Caffeine:	Daily	Weekly	Occasionally	Never
Drugs:	Daily	Weekly	Occasionally	Never
Tobacco:	Daily	Weekly	Occasionally	Never
Exercise:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never

Name _____

Date _____

HIPAA Privacy Policy

I understand that I have certain rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize TOTAL HEALTH ASSOCIATES to use and disclose my protected health information to carry out treatment, including direct or indirect treatment by other healthcare providers involved in my treatment, obtaining payment from third party payers and day to day healthcare operations of TOTAL HEALTH ASSOCIATES. I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that THA reserves the right to change the terms of this notice and that I may contact THA at any time to obtain an up-to-date copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, however, THA is under no obligation to comply with these requested restrictions. In the case that restrictions are mutually agreed upon THA is bound to comply with these new restrictions. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____

Name _____

Date _____

Financial Policies and Procedures

Total Health Associates is an out of network healthcare provider. Total Health Associates uses the out of network benefit information that has been provided to us by your insurance company. These benefit guidelines have been verified; however, they are not a guarantee of payment. In most cases, Total Health Associates will assist the patient in submitting claims and providing any documentation to facilitate the reimbursement process. In the case that your insurance carrier denies payment, you are personally responsible for all fees incurred at Total Health Associates.

I am responsible for understanding my insurance benefit information. I also understand that I am responsible for my account balance(s) in the case that my insurance provider denies payment.

Signature_____Date _____

If you are a Blue Cross Blue Shield member, provider reimbursement checks will be made out and mailed directly to you. Please remit these checks to our office for payment of services within 14 days of receipt. Total Health Associates will keep a credit card on file to be used in the case that insurance checks are not submitted to the office for payment.

I authorize Total Health Associates to charge my credit card for services in the case that paid-to-patient insurance checks are not submitted to the office for reimbursement.

Our office required 24 hours' notice for any cancelations. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or if I do not show for an appointment, I will pay a cancellation/no show fee of $50 for chiropractic or regular physical therapy treatments or $75 for one-on-one physical therapy treatments.

Patient name: _____

Credit Card #_____CVV_____Exp. _____

Signature:_____Zip code _____

Name _____

Date _____

Informed Consent for Chiropractic Treatment

Due to the nature of Chiropractic treatment, the Doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or a "pop", such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used. As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscular strain, ligament sprain, dislocation of joints or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A small percentage of patients may notice stiffness or soreness after the first few days of treatment. Ancillary procedures may cause skin irritation, burns or other minor complications, however, these complications are rare.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition. I hereby authorize the doctors and licensed providers of THA to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or if I do not show for an appointment, I will pay a cancellation/no show fee of $50.

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____

Informed Consent for Physical Therapy

As is the nature of Physical Therapy, the Physical Therapist will use different manual approaches to stretch and facilitate movement to joints or soft tissue. In addition, some activities and exercises that may cause transient muscle soreness. You may feel mild discomfort during a stretch, but not intolerable pain. Various ancillary procedures, such as hot or cold packs, electric stimulation and therapeutic ultrasound may also be utilized. There are no significant risks with Physical Therapy. The ancillary procedures can produce skin irritation or minor superficial burns to those patients who have hyper sensitive skin. The probability of adverse reaction is considered rare. However, if undesirable discomfort is felt during the time of treatment, please let your Physical Therapist know immediately. It is important that you advise and communicate with your Physical Therapist about medical procedures such as minor surgeries, recent hospitalizations, doctor's visits, changes in medication, falls or any significant occurrence as they may present a contraindication and risk to continuing Physical Therapy. Physical Therapy is a system of health care delivery. As with many health care delivery systems we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. If results are not acceptable, we will refer you to another health care provider for additional assistance.

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to TOTAL HEALTH ASSOCIATES. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctors and licensed providers to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or if I do not show for an appointment, I will pay a cancellation/no show fee of $50 for regular or $75 for a one-on-one treatment.

Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date _____