wolke CHIROPRACTIC & REHABILITATION

Patient Application Form

Please Fill Out *Todays' Date:*

PATIENT INFORMATION:

Patient Name: Date Of Birth: Age: Male Female

Address: Apt#: SSN:

City: State: Zip Code: Home Phone:

Alternate Phone (Cell): Email Address:

Employer's Name: Occupation:

Work Address: City: State: Zip:

Work Phone: Ext: Date Symptoms Began:

Marital Status: Single Married Widowed

How did you hear about us?:

Emergency Contact: Phone:

IS YOUR CONDITION FROM AN AUTOMOBILE ACCIDENT? YES NO

INSURANCE INFORMATION:

Relationship to insured: Self Spouse Other Child Name of insured:

Insured's Employer: Same as above OR

Insured's SSN: Same as above OR

Insured's DOB: Same as above OR

Primary Insurance Company: Address:

City: State: Zip Code: Phone:

Policy Number: Group Number:

Secondary Insurance Company: Address:

City: State: ZipCode: Phone:

Policy Number: Group Number:

AUTHORIZATIONS:

A) I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B) I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C) I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Signature: Date:

Guardian Signature: Date:

Current Health Status **Name:**

Describe Complaint #1:

Describe Complaint #2:

Describe Complaint #3:

Is It? ○ Increasing ○ Decreasing ○ Unchanged. Have you had this problem before? ○ Yes ○ No When?

Auto Accident ○ Y ○ N Date of accident: Work Related: ○ Y ○ N Date:

Does it interfere with any daily activities?

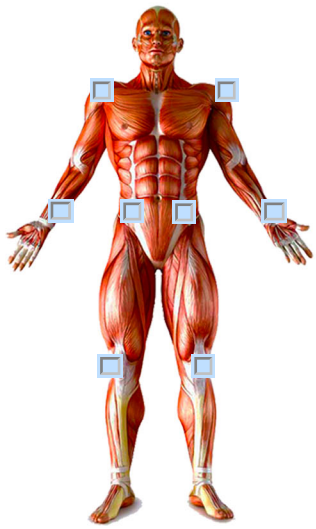
What aggravates it?

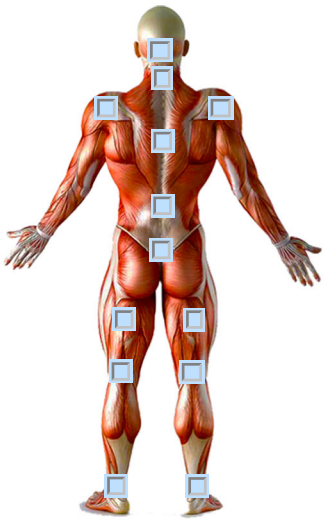
What relieves it?

Is the condition worse: ○ In the AM ○ In the PM ○ No Difference

Does the pain travel? ○ Y ○ N Where?

Check the area/area's you have discomfort:
Pain, Aches, Tingling, Numbness, Spasm





FREQUENCY of your pain or complaint is? (Check only one)

○ **Constant** 100% ○ **Frequent** 75% ○ **Occasional** 50% ○ **Intermittent** 25%

INTENSITY of your pain or complaint is? (Check only one)

○ **Minimal:** Annoyance with no effect on activity

○ **Minor:** Tolerable with some impairment to activity

○ **Moderate:** Tolerable with marked impairment of activity

○ **Severe:** Intolerable and cannot perform any activity

QUALITY of your pain or complaint is? ☐ **Dull** ☐ **Achy** ☐ **Sharp** ☐ **Burning** ☐ **Tingling** ☐ **Numbness** ☐ **Weak**

PAIN SCALE: On a scale of **1-10** (with 10 being the worst) what is your overall pain?

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10** ○

What medications are you currently taking? abc def ghi

Name of Doctor's treating this condition? Current Prior

Phone Number:

Have you had chiropractic care before? ○ Y ○ N When/with whom:

Have you had one or more of the following?

☐ Aneurysm	☐ Osteoporosis	☐ Diabetes	☐ Arthritis	☐ Respiratory Conditions
☐ Epilepsy	☐ Cancer	☐ Strokes	☐ Allergies	☐ Heart Conditions
☐ Hepatitis	☐ Anxiety Attacks	☐ Fatigue	☐ Polio	☐ Sleeping Difficulty
☐ Pneumonia	☐ Pace Maker	☐ HIV	☐ Sinus Conditions	☐ Hypertension
☐ Thyroid Problems	☐ Depression	☐ Scoliosis	☐ Headaches	☐ Migraines
☐ Fainting	☐ Kidney Disease	☐ Parkinson's		

Other:

Female Only

1) Are you pregnant or by any chance you may be?

2) Date of the start of your last period:

3) Are you on any type of Birth Control?

Any Concerns?

Patient Signature: Date:

Wolke Chiropractic & Rehabilitation

APPOINTMENT CANCELLATIONS:

If I am unable to keep my scheduled appointment, I will call Wolke Chiropractic & Rehabilitation to cancel or re-schedule my appointment. All appointments require a 24 business hour cancellation notice. If I do not call Wolke Chiropractic & Rehabilitation to cancel my appointment, I may be charged the no show fees listed below.

NO SHOW/ FAILURE TO CANCEL WITHIN TIME FRAME OUTLINED ABOVE:

Failure to arrive for my scheduled appointment may result in a $25.00 fee for each regular appointment.

CO-PAYMENT POLICY:

Co-payments are due and collected on the day of my appointment or at the beginning of each week of treatments.

INSURANCE/ PRESCRIPTION POLICY:

It is my responsibility to know if my insurance plan requires a prescription to see a specialist. If my insurance plan requires a prescription. It is my responsibility to obtain an updated prescription from my referring Doctor and to make sure Wolke Chiropractic & Rehabilitation has said prescription prior to my appointment. I understand that without a valid prescription for my visit Wolke Chiropractic & Rehabilitation may not be able to see me for my visit.

INSURANCE POLICIES:

I will confirm my insurance is current at each visit. If there is a change to my insurance I will provide a valid insurance card or temporary print out at the time of my visit. Each insurance plan is different and I understand it is my responsibility to understand my policy and what will be covered. I also understand that Wolke Chiropractic & Rehabilitation is out of network with all insurance carriers. I understand that as an out of network provider my insurance company may send all payments directly to me, I will promptly turn over all checks and paperwork that comes to me within 7 days of receiving the check or I may be held responsible for the full balance of my account. I understand in signing below that I am responsible for notifying Wolke Chiropractic & Rehabilitation of any changes to my insurance or contact information. If insurance or prescription information I present at the time of my visit is not correct, I will be responsible for all changes incurred.

ACCOUNT BALANCES:

All balances are due in full within 30 days of my first billing. If my balance is left unpaid for 90 days it will be considered for collections. It is my responsibility to contact the office to arrange for an acceptable payment plan should I be unable to pay my balance in full. Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney/court fees which may be added to my account during efforts to obtain payment. I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

MINOR PATIENTS:

A legal guardian MUST ACCOMPANY children under the age of 18 in their initial appointment so that proper forms can be completed and your child can be treated. Children without legal guardian at their first visit will be rescheduled. Signed forms in lieu of parents/guardian's attendance are not acceptable. Grandparent's, babysitters, older siblings ect are not considered legal guardians without appropriate paperwork and the appointment will be rescheduled.

INSURANCE INQUIRIES:

From time to time I may receive a letter my insurance company requesting information about my coverage. I understand that claims will not be paid without my providing this information. I will reply to all insurance inquiries within 30 days of receipt or the balance will become my responsibility to pay.

Patient or Legal Guardian Signature: _____ Date: _____

Statement of Non-Accident

Date:

Dear Insurance Carrier:

I, , am currently receiving care at Wolke Chiropractic & Rehabilitation, this facility. Please know that this care is NOT RELATED to any automobile accident, workers' compensation injury, or any other type of injury which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

Initials

Signature Date

Wolke Chiropractic & Rehabilitation
535 High Mountain Road Suite 104
North Haledon, NJ 07508
(973) 423-9001 (973) 423-5525 Fax

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

Patients Name:

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against my Health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments on this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

I authorize you and your assigned to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, to you about me, including medical reports, X-ray reports, narrative reports, and any other report information regarding my physical condition.

Dated:

Patient Signature

HIPAA AUTHORIZATION FORM FOR RELEASE/REQUEST FOR RECORDS

PATIENT NAME: DOB:

PATIENT ADDRESS:

I hereby authorize release or disclosure of protected health information about me to:

Wolke Chiropractic & Rehabilitation
535 High Mountain Road
North Haledon, NJ 07508
T: (973) 423-9001 F: (973) 423-5525

The specific information that should be disclosed is:

I understand that the information released or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Wolke Chiropractic & Rehabilitation in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

Date:

Signature of Patient
(the person about whom the information relates)
OR, *if applicable*
Signature of Guardian if Patient is a minor

UNLESS THERE IS A SIGNATURE HERE, NO INFORMATION ABOUT ALCOHOL/ SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION:

NO, DO NOT DISCLOSE THIS INFORMATION: