

# JERSEY WELLNESS CENTER

35 W. Main Street, Suite 202, Denville, NJ 07834 T: 973-625-7800/F: 973-627-6982 info@jerseywellnesscenter.com

## NEW PATIENT FORMS

Please complete the attached forms and bring them with you on your first appointment to our office. Also, please bring your insurance card, a photo identification, current medication list and any recent lab work, x-rays, mri, etc.

This office is a participating provider with Aetna, BC/BS, Cigna and Medicare.

Although we participate with the above plans, occasionally some policies may exclude our office or require you to pay higher deductibles and out of pocket expenses. For example: BC/BS Omnia: We are a tier 2 provider with this plan. If you have this plan and you choose to be treated in our office, you will be subject to higher out of pocket expenses. (high deductible and coinsurance)

All other insurance plans are accepted and your out of network benefits (if applicable) will apply.

### Attention Managed Care Plans:

If your insurance plan requires a referral to see a Specialist, please contact your primary care Physician to obtain one prior to your first visit.

They can fax the referral to our office at 973-627-6982, email to info@jerseywellnesscenter.com or you can bring it with you on your first visit.

Here are some numbers you may need for your referral:

Dr. Jersey Wulster Individual NPI#: 1982776233/Jersey Wellness Center- Group NPI#: 1881966547

## PATIENT INFORMATION

Last name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
First name: \_\_\_\_\_ Gender: [ ] Male [ ] Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Address: \_\_\_\_\_ Marital status: [ ] single [ ] married [ ] divorced [ ] widowed  
\_\_\_\_\_ [ ] separated [ ] other  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Decline  
Email address: \_\_\_\_\_ Race: [ ] Caucasian/White [ ] African American/Black  
Home #: \_\_\_\_\_ [ ] American Indian/Alaskan Native [ ] Asian  
Work #: \_\_\_\_\_ [ ] Pacific Islander [ ] Other [ ] Decline  
Cell #: \_\_\_\_\_ Your preferred language: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Number: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Address and number: \_\_\_\_\_  
Who referred you to our office: \_\_\_\_\_

## EMPLOYMENT INFORMATION

[ ] Employed [ ] Unemployed [ ] Retired [ ] Other  
Employer: \_\_\_\_\_ Your Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ Years in this field of work: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company : \_\_\_\_\_ Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Policy Holders Name: \_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_ Gender: male / female  
Your relationship to the Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other  
Do you have a secondary insurance: [ ] YES [ ] NO Secondary Insurance Companies Name: \_\_\_\_\_  
Policy Holders Name: \_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_ Gender: male / female  
Your relationship to the Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other

NOTE: As a policy our office typically does not submit to your secondary insurance and it is your responsibility to do so. Sometimes special insurance related circumstances may apply, so please inform the front desk if you have a secondary insurance.

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if patient is a under 18): \_\_\_\_\_ Date: \_\_\_\_\_

LAST NAME: \_\_\_\_\_, FIRST NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### WHAT BRINGS YOU HERE TODAY?

What is your current complaint that brings you to our office today? \_\_\_\_\_

Pain or discomfort in: Head / Neck / Shoulder / Arm / Upper Back / Mid Back / Low Back / Hip / Groin / Buttocks / Leg / Knee / Ankle / Foot

Date problem began? \_\_\_\_\_ Describe how the problem began? \_\_\_\_\_

Describe the pain: ache / burning / dull / numb / radiating / sharp / shooting / sore / spasm / stabbing / stiff / throbbing / tingling / weak

Rate the intensity of your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

How often in the pain present? 0% - 25% 26% - 50% 51% - 75% 76%-100%

In the past week, how much has you pain interfered with your daily activities (e.g. work, social, household, sports, etc)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities

In general, how would you describe your overall health: Excellent / Very Good / Good / Fair / Poor

Does it bother your: [ ] work [ ] sleep [ ] other (specify) \_\_\_\_\_

Is the condition: [ ] job related [ ] auto related [ ] other \_\_\_\_\_

Is this the first time that you experienced this complaint? Yes / NO Explain: \_\_\_\_\_

What treatment, tests, medications have you had to date for this complaint? Include dates if known \_\_\_\_\_

Name of Physicians, Labs, Testing Facilities, Hospitals you have been to for this condition.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

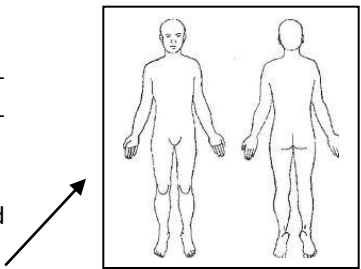
Date: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What is your current stress level? no stress / minimal stress / moderate stress / greatly stressed

On the body diagram, please mark the area/s of your discomfort and describe your pain at their locations.



Have you had any of the following? Indicate your age or the year it was performed.

Appendectomy \_\_\_\_\_ Hysterectomy \_\_\_\_\_ Broken Bones \_\_\_\_\_ Cancer \_\_\_\_\_ Hernia \_\_\_\_\_ Gall Bladder \_\_\_\_\_

Back Surgery \_\_\_\_\_ Tonsillectomy \_\_\_\_\_ Other \_\_\_\_\_

Accident or Major Falls (include auto/job accidents): \_\_\_\_\_ Date: \_\_\_\_\_

Hospitalization (other than above): Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Previous Chiropractic Care: YES / NO Doctor's name and approximate date of last visit: \_\_\_\_\_ Treated for: \_\_\_\_\_

Family M.D. \_\_\_\_\_

Are you under the care of a physician? YES / NO If yes, for what: \_\_\_\_\_

Medications you are currently taking:

Medication: \_\_\_\_\_

Taking for: \_\_\_\_\_

Medication: \_\_\_\_\_

Taking for: \_\_\_\_\_

Medication: \_\_\_\_\_

Taking for: \_\_\_\_\_

Do you take vitamins, herbs or supplement: YES / NO

Do you have any allergies? (drugs or other) YES / NO If yes, to what: \_\_\_\_\_

Do you have any other non-drug related allergies? YES / NO If yes, to what: \_\_\_\_\_

Do you have a family history of: low back pain / neck pain / headaches / migraines / shoulder pain / bursitis / sciatica / heart problems / cancer /diabetes

INITIAL: \_\_\_\_\_

## MEDICAL HISTORY

	PRESENT	PAST
mumps		
small pox		
chicken pox		
measles		
polio		
whooping cough		
rheumatic fever		
pneumonia		
venereal disease		
shingles		
hepatitis		

	PRESENT	PAST
heart disease		
hardening of arteries		
anemia		
kidney problems		
tuberculosis		
lymes disease		
mental disorder		
arthritis		
epilepsy/convulsions		
high blood pressure		
diabetes		

	PRESENT	PAST
cancer		
hyperthyroid		
hypothyroid		
other thyroid issues		
immune disorder		
AIDS		
HIV		
liver disease		
migraines		
drug addiction		
alcoholism		

### CURRENT MEDICAL COMPLAINTS/ISSUES

#### MUSCULO-SKELETAL

low back pain	
upper back pain	
neck pain	
arm pain	
joint pain/stiffness	
walking problems	
difficulty chewing	
clicking jaw	
general stiffness	
shoulder pain	
leg pain	
knee pain	

#### ENDOCRINE

fatigue	
hair thinning	
thyroid problems	

#### NERVOUS SYSTEM

nervous	
numbness	
paralysis	
dizziness	
forgetful	
confusion	
depression	
fainting	
cold hands	
cold feet	
stress	

#### GENITO-URINARY

bed wetting	
blood in urine	
frequent urination	
bladder control issues	
painful urination	
prostate trouble	
pus in urine	
bladder infections	

#### CARDIOVASCULAR

chest pain	
shortness of breath	
blood pressure problems	
irregular heartbeat	
heart problems	
lung problems/congestion	
varicose veins	
ankle swelling	
stroke	
heart attack	

#### ENT

vision problems	
dental problems	
sore throat	
ear aches	
hearing difficulties	
recurrent stuffy nose	
sinus infections	
ringing in ears	

#### GASTRO-INTESTINAL

poor appetite	
excessive appetite	
frequent nausea	
vomiting	
diarrhea	
constipation	
hemorrhoids	
liver problems	
gall bladder problems	
weight troubles	
abdominal cramps	
gas/bloating	
heartburn	
black/bloody stools	
colitis	
lactose intolerant	
gluten problems	
digestive issues	
irritable bowel syndrome	
ulcer	

#### GENERAL

fatigue	
allergies	
loss of sleep	
sleep apnea	
headaches	
hair thinning	

#### WOMEN ONLY

congested breasts	
cycle cramps	
abnormal periods	
excessive bleeding	
irregular cyle	
lumps in breast	
menopause	
painful menstruation	
vaginal discharge	

Last menstrual period: \_\_\_\_\_

Are you pregnant: YES / NO

If yes, how far along: \_\_\_\_\_

Number of children: \_\_\_\_\_

Last gyno exam: \_\_\_\_\_

OB/GYN name: \_\_\_\_\_

#### PRESENT INTAKE OF: PER DAY

reg coffee	_____
dec coffee	_____
reg tea	_____
dec tea	_____
alcohol	_____
cigarettes	_____
white sugar	_____

#### SMOKING STATUS (circle)

PRESENT

PAST

NEVER SMOKED

INITIAL: \_\_\_\_\_

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Dr. Jersey Wulster Individual NPI: 1982776233

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**AUTHORIZATION TO TREAT & EXAMINE**

I hereby authorize consultation, examination and treatment by the Doctors at Jersey Wellness Center as they determine appropriate for me and my health concerns.

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature/parent or guardian

\_\_\_\_\_  
Date

**RECORDS RELEASE**

I hereby authorize copies of my medical records to be sent to Jersey Wellness Center. Records can include Doctors notes, x-rays, mri, CT scan or other pertinent medical information as requested by and released to: Jersey Wellness Center

35 W. Main St, Ste 202

Telephone: 973-625-7800/Fax: 973-627-6982/email: info@jerseywellnesscenter.com

Denville, NJ 07834

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature/parent or guardian

\_\_\_\_\_  
Date

**PRIVACY PRACTICES**

A copy of our Privacy Practices is on our website for viewing at [www.drjersey.com](http://www.drjersey.com) in addition a hard copy is visible in our patient waiting room. You may request a copy of our Privacy Practices at any time from our front desk.

I have been provided with a copy of Jersey Wellness Center, LLC Notice of Privacy Practices, which describes Jersey Wellness Center, LLC use and disclosure of my Protected Health Information (PHI)

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature/parent or guardian

\_\_\_\_\_  
Date

**ASSIGNMENT OF BENEFITS TO OUR OFFICE**

I hereby authorize direct payment of my insurance reimbursements to Jersey Wellness Center.

I am herein noticed that an insurance company, based on its own policies and guidelines, may make different determinations of the medical necessity of my treatments received at Jersey Wellness Center. This insurance company determination may result in decreased payment or non-payment of some or/all services from my insurance company. I acknowledge that I understand the above statement and agree to be personally responsible for payment of any service/s rendered to me (or my child) by Jersey Wellness Center that is NOT reimbursed by my Insurance Company. I hereby authorize the office of Jersey Wellness Center to release any healthcare information in compliance of HIPAA, to my insurance company, utilization review company or attorney that may be requested. ▼

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature/parent or guardian

\_\_\_\_\_  
Date

# JERSEY WELLNESS CENTER - NO BILLING POLICY

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Our office has a no billing policy. This simply means that our office makes every attempt to not have to bill patients for outstanding balances. Our billing policy is as follows and you must choose which financial plan to accept:

1. This can be payment in full at each visit (CASH PATIENT)
2. Payment paid ahead of services (PRE-PAY PATIENT)
3. Payment paid at the beginning of each month for the entire family (FAMILY PLAN)
4. Payment of co-pay, coinsurance, deductibles, charges above what your insurance company allows, etc (INSURANCE PATIENT).

**Please circle your choice of payment to our office: cash, pre-pay, family plan or insurance option**

## CASH PATIENT

This means that you will pay in FULL at the time services are rendered. You will not carry a balance in this office. (If you have insurance, you can submit the claims to your insurance company or we can submit it for you and have payment be sent directly to you. Not valid with BC/BS, Aetna, Medicare or Cigna). You can leave a credit card on account to be billed at each visit or you can pay by cash, check or credit card at each visit. If you are experiencing significant financial difficulties and you have a true financial hardship, please advise the staff. You will then need to fill out financial hardship paperwork and a determination of the payment amount for your services will be based on your financial situation and your ability to pay.

## PRE-PAY PATIENT

You can pre-pay in advance for your services. We have several pre-pay plans available. A pre-pay plan will give you a reduced fee structure for your services. This is a cost effective plan for patients that have no chiropractic coverage or no insurance at all. If you are interested in a pre-pay plan, please inform the front desk.

## FAMILY PLAN

Our office does offer family plans to families that have no chiropractic coverage or no insurance. Family plans are a set amount paid monthly (prior to the month of services) that covers chiropractic services for your family. Please ask the front desk for more information.

## INSURANCE OPTION

We encourage you to be fully aware of the provisions of your own insurance policy. You can do this by completing an Insurance Verification Form (that we will provide to you). As a courtesy to you, we will submit to your primary insurance company. You are responsible for any outstanding balances (services not paid by your insurance: co-pays, coinsurance, deductible, charges above what your insurance company allows, denials, etc). Outstanding balances or fees not covered are payable at your time of service and/or when an explanation of benefits (EOB's)/remittance advice are posted to your account. **If you choose the insurance option, our office requires that a credit card is on file to be used if there is an outstanding balance on your account that remains unpaid by you for 60 days.** Your credit card will be charged after all reasonable attempts have been made to collect from insurance companies and individuals alike. The only 60 day exception is when there is a problem with your insurance processing by our office, medical necessity issue that we are working on with your insurance company or if other financial arrangements are made with you in advance with our office. If you refuse to leave a credit card on file, please bring payment at each visit as you **MUST PAY** your portion of services or patient balance at time of each visit.

***In absence of payment of any balances due by a patient beyond the 60 day period is sent to an outside collection agency for follow up unless special financial arrangements have been made in advance.***

Please provide us with your credit card information: MC / VISA / DISCOVER (circle one)

Name on card: \_\_\_\_\_ Credit Card #: \_\_\_\_\_

Expiration date: \_\_\_\_\_ CVN #: \_\_\_\_\_ (3 digit number on back of credit card)

I give my authorization for Jersey Wellness Center to charge my credit card listed above for any balance that is outstanding beyond the 60 day grace period. \_\_\_\_\_

Signature

Date

The above information that I have provided is true and accurate and I have read and understand the above financial policy of Jersey Wellness Center. \_\_\_\_\_

Signature

Date