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.
****

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

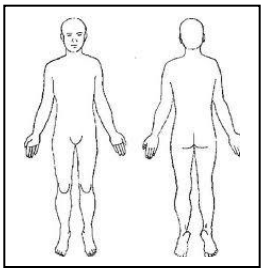
In general, how would you describe your overall health: Excellent / Very Good / Good / Fair / Poor

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:

LAST NAME: _____, FIRST NAME: _____ DATE: _____

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 wedding	
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:

JERSEY WELLNESS CENTER

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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 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

Privacy Notice of
Jersey Wellness Center, LLC.

This notice describes the type of information we gather about you and describes with whom that information may be shared. It also describes safeguards we have in place to protect information about you. We sometimes refer to ourselves in the notice as "Practice".

You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information about you, except when law requires us to release the information. If the practices described in this notice regarding your medical information are satisfactory to you, you do not have to do anything further. If you prefer that we not share information, we may honor your written request in certain circumstances which are described in this notice. If you have any questions about this notice, please contact our Privacy Officer at the address on the last page.

Who Will Follow This Notice

This notice describes our practices regarding the use of your medical information. We maintain records documenting our treatment of you called Medical Records. Medical Records contain not only information regarding the nature and extent of services provided during office visits, but test results, x-ray, hospital records, records of other doctors treating you, your medical history, orders and prescriptions and other similar records related to your medical care. Our physicians and health care personnel enter information into your medical record. In addition, we maintain billing records regarding your care, which necessarily contain information regarding your health care and treatment in the practice**.**

Entries are made in the records by our staff including our physicians and health care personnel in case of medical care and our billing personnel in case of billing records. This notice applies to all of the records containing protected health information related to your care generated in the Practice whether made by health care professionals or one of our personnel.

The purpose of this notice is to tell you about how we may use and disclose medical information about you. The notice also describes your rights and certain obligations we have, regarding the use and disclosure of your medical information.

We are required by law to keep medical information that identifies you private; give you this notice of our legal duties and privacy practices with respect to health information we maintain about you; and to follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information about You

There are three basic categories of ways in which we may use and disclose your health information with your consent.

Treatment - We may use medical information about you as necessary to provide medical treatment. We may also disclose your medical information to physicians and other health care professional who are involved in taking care of you, whether within our Practice or outside of our Practice.

Health care personnel in our Practice may share information about you amongst themselves or with health care professionals outside the Practice who are treating you to coordinate care, such as medical history, sharing test results, prescription information and x-rays. Sharing of information would also be necessary with respect to referrals we make. For example we may refer you to an outside physician, such as a radiologist for x-rays or tests needed to treat and diagnose your medical condition.

For Payment - In order to bill and collect for our services we use and disclose medical information about you including an insurance company or third party. For example, your insurance may need to know about care you receive in order to pay our Practice for services we provide to you. We may also use and disclose medical information about you to determine your eligibility for insurance payment and where required to obtain prior approval or for coverage determinations for particular services. In addition, we may disclose medical information about you to billing companies we use to process billing and collections.

For Health Care Operations - We use medical information about you to review the quality and utilization of care in our Practice, including evaluating compliance by our staff and personnel with professional and billing standards to assure that our patients receive quality care in an economically and efficient manner.

For example, we may use medical information about you as part of a sampling to review, maintain and improve the quality of treatment and services our patients receive. In the course of such reviews we may disclose information to physicians, nurses, technicians and other Practice personnel on our staff. We may also disclose information to our medical liability insurer for purposes of evaluating care provided in our Practice. We may remove information that identifies you from information we share or use so others may use it to study health care and health care delivery in our Practice without learning who you are. In addition, we may disclose health information about you to persons who provide transcription services for reports and records we are required to make and maintain regarding services to you.

Appointment Reminders – We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. For instance we may call you and leave a message with someone who answers your home phone or on your home answering machine, to confirm or schedule an appointment.

Treatment Alternatives - We may use and disclose medical information to tell you about or recommend possible treatment options or alternative that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member and who is involved in your medical care. We may also give information to someone who helps pay for your care.

As required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety - We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations:

We may release medical information about you for the following other reasons:

To our military authorities, if you are a member of the armed forces.

For Worker's compensation or similar programs which provide medical benefits for work related illnesses or injuries.

activities monitor the health care system, government programs and For public health activities, including: to prevent or control disease, injury or disability; to report births and deaths; to report to government authorities actual or suspected child or other abuse, neglect or domestic violence; to report reactions to medications or problems with products; to notify people of recalls of products they may have been exposed to disease or may be at risk for contracting or spreading a disease or condition.

To comply with laws, rules and regulations governing consents regarding birth defects and cancer.

To comply with special New Jersey State Laws, which we observe, requiring your consent to the disclosure of information regarding genetic information and test results.

To comply with laws regarding mandatory reporting requirements to the Commissioner of Health of the State of New Jersey regarding HIV, AIDS and HIV related illness.

To cooperate and comply with government health oversight agencies requirements with respect to audits, investigations, inspections and licensure review authorized by law which compliance with civil rights laws.

To fulfill legal duties in response to a subpoena, discovery request or other lawful order from a court directed to the Practice.

If asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

To identify a deceased person, to determine the cause of death or as otherwise necessary to a coroner, medical examiner or funeral director to carry out their duties.

To respond to requests from authorized federal official for protection of the President, other authorized persons or foreign heads of state or conduct special investigations or for intelligence, counterintelligence and other national security activities authorized by law.

Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information we maintain about you.

Right to Inspect and Copy. Right to Inspect and Copy.

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address on the last page. If you request a copy of the information, we may, except in some limited circumstances, charge a fee for the costs of copying, mailing or other supplies associated with our request, not to exceed a reasonable charge per page. We can also place reasonable limitations on the time, place and frequency of inspections.
We may deny your request to inspect and copy in certain very limited instances. If you are denied access to medical information, you may request that the denial be reviewed. We will comply with the outcome of the review.

A denial of a request for access may also, in certain circumstances, be the subject of a review if requested by you by the Practice or of a complaint to the Secretary of Health and Human Services. We will provide you with the instructions for filing requests for such reviews or complaints.

Right to Amend - Supplement Information in Your Records. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend and/or you may supplement the information in your medical record. You have the right to request an amendment and/or supplement information in your records, including by having a brief written statement of disagreement included in the record which will accompany any disclosures, for as long as the information is kept.

To request and amendment and/or to supplement information in your records, your request must be made in writing and submitted to our Privacy Officer and where applicable should include the proposed supplemental information. In all cases, you should provide a reason that supports your request for amendment or supplement.

We may deny your request for amendment subject to review for certain designated reasons under the Privacy Laws including that the subject of the amendment:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by the Practice.
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

A denial of a request for access may also be the subject of a complaint to Practice Privacy Officer and/or the Secretary of Health and Human Services and we will provide you with instructions as to how to file such a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Office at eh address on the last page. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a specific way or at a specified alternative location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications you must make your request in writing to our Privacy Officer. We will not ask you for the reason for your request and accommodate all reasonable requests. Your request must specify how or where you wish o be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically.

Request for paper copies should be made in writing to our Privacy Officer at the address on the last page.

Changes to This Notice. We reserve the right s to change this notice and to make a revised or changed notice effective for medical information we already have or which we receive subsequent to such revised or changed notice. We will post a copy of the current notice. The effective date of the notice will be placed in the lower left-hand corner of the first page.

Communications to You
Practice may display your name in public areas in their office for such purposes of referral board, games or contests, etc. Practice may contact you regarding direct patient marketing, health related information and promotional material.

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Privacy Officer at the address and telephone number on this page. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, hereafter we will no longer use or disclose medication information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosers we have already made with your permission and that we are required to retain our records of the care what we provided to you.

Questions
If you have any questions at any time regarding this notice or our privacy practices, we encourage you to write, call or fax to the following.

Attn: Privacy Officer
Jersey Wellness Center, LLC.
35 W. Main Street, Suite 202
Denville, NJ 07834
Telephone: 973-625-7800 / Fax: 973-627-6982
Email: info@jerseywellnesscenter.com

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